An Evaluation of Interprofessional Education for Health and Social Care Professionals: *The Teachers' Views*

by

Siobhán Ni Mhaolrúnaigh

Thesis Submitted in Fulfilment of the Requirements of the Degree of Doctor of Philosophy

The University of Warwick
The Department of Continuing Education
January 2001

ABSTRACT

There is accumulative evidence and successive government policy to suggest that the health and social care professions need to provide integrated services to the public. Interprofessional education is regarded as a solution to the problem and has developed from this demand. Educational initiatives of an interprofessional nature are now a regular occurrence. The role of the teacher in facilitating these programmes has been largely overlooked. The purpose of this thesis was to address this imbalance. The study adopted the illuminative evaluation paradigm to investigate the teachers' perceptions of interprofessional education and shared learning milieu. It took the form of three surveys. The first survey addressed the perceptions of the course leaders in centres for teacher education. The second survey involved new teachers, mentors and managers in colleges for nursing and midwifery education at that time. The third survey addressed interprofessional education from the perceptions of teachers of health and social care professions who were involved in IPE programmes in higher education. The central research question underlying the study was how do teachers view and implement IPE? Essential to this was the question *are teachers prepared for their role in interprofessional education?* Multiple methods were used to collect the data and both quantitative and qualitative methods were used in analysis. Non parametric statistics were applied to quantitative data. Computer assisted analysis was used for the qualitative data through a purpose built database using ACCESS software. The results showed that teachers or students did not have preparation for interprofessional education while the majority of teachers felt that they required it. The evidence suggested a lack of commitment at strategic level, and a lack of structuring and planning of resources to accommodate this type of education. Teachers were aware of the benefits interprofessional education could offer, but were sceptical as to the motives underlying it. In reality, interprofessional education was less than the proposed principles behind it.

ACKNOWLEDGEMENTS

I wish to acknowledge and give sincere thanks to the participants in this study. Their assistance and support in the accumulation of evidence is greatly appreciated. A special thanks to my supervisor Professor Malcolm Tight for his consistent support and advice. Thanks also to the English National Board (ENB) for Nursing, Midwifery and Health Visiting, Professor Collette Clifford, Professor Caroline Hicks and the Steering Group members who showed confidence in me through the first stage of this work. I say a special thanks to by brother Seán for his patience and help in troubleshooting my many computer problems.

DECLARATION

Part of the content of this thesis relates to research commissioned by the English National Board (ENB) for Nursing, Midwifery and Health Visiting, London (Mhaolrúnaigh et al, 1995). Publications from this stage are listed as follows:

(a) Refereed Publications:

Mhaolrúnaigh S. Clifford C. (1998): A Review of Teacher Preparation for Shared Learning Environments **Nurse Education Today 18**: 178-182

Mhaolrúnaigh S, Clifford C, Hicks C. (1995) **An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife And Health Visitor Teachers** London English National Board

Mhaolrúnaigh S (1995) Using an Illuminative Paradigm in Researching Shared Learning **CAIPE Summer**

Mhaolrúnaigh S (1995) An Evaluation of Shared learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers **CAIPE Autumn**

(b)Refereed Abstracts

Mhaolrúnaigh S (1998) Interprofessional Education for Health & Social Care Professionals: *The role of the teacher.* **Conference Abstracts BERA Edinburgh**

Mhaolrúnaigh S Clifford C. (1994) An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers ***Nursing Research Abstracts*** 94/574 Vol. 16(4)

Clifford C Mhaolrunaigh S. Hicks C. (1995) An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers. **Research Highlights** English National Board London

(c) Refereed Conferences

Mhaolrúnaigh S (1998) Interprofessional Education for Health & Social Care Professionals: *the role of the teacher.* **BERA Conference Belfast.**

Mhaolrúnaigh S Clifford C (1995) An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurses, Midwives and Health Visitors. Concurrent Session **The English National Board** Birmingham NEC

(d) Poster Presentations

Mhaolrúnaigh S Clifford C (1994) An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers. **The English National Board Conference** Birmingham NEC.

Table of Contents

		Page
	Abstract	I
	Acknowledgement	ii
	Declaration	ii
	Publications	ii
	Table of Contents	iii
	List of Tables	iv
	List of Figures	v
	Chapter 1: Introduction to Thesis	
	Introduction to Chapter	1
1.1	Background to IPE as an Innovation	1
1.2	Policy Background	3
1.3	Implications for Professions	5
1.4	Focus of the Thesis	10
1.4.1	Research Statement	11
	Chapter 2: The Concept of Interprofessional Education	
	Introduction to Chapter	12
2.1	Defining Terminology	12
2.2	Traditional Professional Education Versus IPE	18
2.2.1	Intellectual Property of Professions	22
2.3	Implications for Teaching and Learning	26
2.3.1	Models of Teaching, Models of Learning	31
2.4	Building a Conceptual Framework for IPE	40
	Chapter 3: Policy and Practice of Interprofessional Education	
	Introduction to Chapter	47
3.1	NHS Government Policy Influences on Education	47
3.2	Recent Government Policy Implications	54
3.3	Implications of Policy for Professions	61
3.3.1	Working in Partnership	62
3.3.2	Task and Maintenance Functions	67
3.4	Implications of Policy for Education	70
3.4.1	IPE for Interprofessional Practice	71
3.4.2	IPE and Professional Education	74
3.4.3	IPE and Teacher Education	81
	Chapter 4: Research Design and Methodology	
	Introduction to Chapter	83
4.1	Aims of Study	84
4.2	Choosing a Design for the Research	84
4.2.1	Evaluation of IPE	86
4.2.2	Evaluation as a Research Method	87
4.3	Design of The Study	91
4.3.1	Overview of Methods of Data Collection	92
4.3.2	Validity and Reliability	94
4.4	Selecting and Piloting the Research Measurement Instruments	95

4.5	Survey One	96
4.6	Survey Two	97
4.7	Survey Three	99
4.8	Data Analysis	103
4.8.1	Computer Assisted Analysis	104
4.8.2	Quantitative Data Analysis	106
4.8.3	Qualitative Data Analysis	107

Chapter 5: Quantitative Data Analysis

	Introduction to Chapter	112
5.1	Survey of Institutions for Nurse/Midwifery/Health Visitor Education	112
5.1.1	ENB Structure and Policy of Teacher Education	114
5.1.2	Organisational Context for Teacher Education	116
5.1.3	Objectives for Shared Learning	119
5.1.4	Goals for Shared Learning	121
5.1.5	Collaboration	122
5.1.6	Preparation for Shared Learning Environments	124
5.1.7	Implementation of Shared Learning	124
5.1.8	Evaluation Methods	125
5.1.9	Summary of Survey One	127
5.2	New Teachers' Impressions of their Preparation and Role	128
5.2.1	Demographic Detail of Respondents	128
5.2.2	Structure and Policy of Teacher Education	131
5.2.3	New Teachers' Evaluation of Preparation for Their Role	134
5.2.4	Summary of Part One of Questionnaire	136
5.3	Role of New Teachers in Colleges	136
5.3.1	Professional Development Opportunities	137
5.3.2	Preparation of Teachers and Students for Shared Learning	138
5.3.3	New Teachers' Perceptions of Shared Learning	139
5.3.4	Summary of Part Two of Questionnaire	141
5.4	Views of Teachers in Higher Education	142
5.4.1	Results of Survey Three	143
5.4.2	The Composition of IPE Group(s) in Higher Education	145
5.4.3	Shared Learning in Professional Practice	151
5.4.4	Preparation of Staff and Students	151
5.4.5	Teachers' Skills in Shared Learning	153
5.4.6	Defining Interprofessional Education	153
5.4.7	Teachers' Views of Attributes of Shared Learning	155
5.4.8	Summary of Survey Three	156
5.5	Comparison of Quantitative Findings	157
5.6	Summary of Chapter	164

Chapter 6: Qualitative Data Analysis

	Introduction to Chapter	165
6.1	Profile of Shared Learning in the Context of Teacher Education	166
6.1.1	Case Studies	166
6.1.2	Collaboration and Competition in Teacher Education	169
6.1.3	Curriculum Context	170
6.2	Profile of Shared Learning in the Context of Colleges	173
6.2.1	Pre-Qualifying Education	173
6.2.2	Post-Qualifying Education	174
6.3	Profile of Shared Learning in the Context of Higher Education	176
6.4	Organisational Influences on IPE	177
6.4.1	Driving Forces	178

6.4.2	Beneficial Outcomes of. and Barriers to Shared Learning	181
6.4.3	Policy Implications for IPE	183
6.5	Teachers' Values and Beliefs	186
6.5.1	Teachers' Perceptions of their Role in IPE	188
6.5.2	Teachers' perceptions of their Role in Professional Practice	191
6.5.3	Preparation of Teachers and Students	193
6.5.4	Evidence of Teacher and Student Preparation	199
6.6	Models of Teaching and Learning	204
6.6.1	Teaching Strategies used for IPE	210
6.6.2	Collaborative Teaching and Learning	211
6.7	Curriculum Context: Learning Milieu	212
6.8	Characteristics of IPE	218
6.9	Summary of Chapter	226

Chapter 7: Discussion and Conclusion

	Introduction to Chapter	229
7.1	Interprofessional Education in Teacher Education	229
7.2	Interprofessional Education in Higher Education	234
7.3	Discussion	243
7.3.1	Implications for IPE Policy	250
7.1.2	Implications for Teaching and Learning	255
7.1.3	Implications for Professions	258
7.1.4	Methodological Implications	259
74	Conclusion	261

References 263

Appendices

Appendix 1	Questionnaire- Course leaders
Appendix 2	Interview Schedule –Course leaders
Appendix 3	Questionnaire-New Teachers
Appendix 4	Interview Schedule - New Teachers
Appendix 5	Interview Schedule-Mentors and Managers
Appendix 6	Questionnaire-Teachers Health and Social Care Professions

LIST OF TABLES

		Page
Chapter 4		
Table 4.1	Categorisation of Interprofessional Initiatives	101
Chapter 5	**Quantitative Data Analysis**	
Table 5.1	Ranked Scores for Objectives for Shared Learning	120
Table 5.2	Mean Scores for Objectives of Shared Learning	120
Table 5.3	Mean Scores for Shared Learning Goals	123
Table 5.4	Collaborating Bodies in Provision of Shared Learning	123
Table 5.5	Nature of Collaboration for Shared Learning Initiatives	123
Table 5.6	Integration of Shared Learning in Curriculum	126
Table 5.7	Methods of Evaluating Shared Learning	126
Table 5.8	Age Range of New Teachers	130
Table 5.9	New Teachers Area of Professional Expertise	130
Table 5.10	Preparation Programmes Completed by New Teachers	130
Table 5.11	Frequency of Professionals in Shared Learning in Teacher Preparation	130
Table 5.12	Frequency of Shared Elements in Programme Content	135
Table 5.13	Integration of Shared Learning in Curriculum	135
Table 5.14	New Teachers' Perceptions of Preparation for Particular Teaching Tasks	135
Table 5.15	New Teachers Additional Preparation through Shared Learning Environment	135
Table 5.16	Support Mechanisms for New Teachers	140
Table 5.17	New Teachers' Perceptions of Shared Learning Attributes	140
Table 5.18	Profile of Participants' in Survey	144
Table 5.19	Percentage of Teachers by Frequency of IPE Groups	144
Table 5.20	Frequency of Occurrence of Professions by Number .of Professions in IPE Groups	147
Table 5.21	Frequency of Professions Associated with Other Professions in IPE Groups	147
Table 5.22	Other(s) Identified in IPE Group Composition	148
Table 5.23	Teachers who facilitated more than One IPE Group Composition	148
Table 5.24	Number of Teachers in Comparison to Group Size	150

Table 5.25	Comparison of Teachers by Profession to Group Size in IPE	150
Table 5.26	Number of Teachers with a Role in Practice Compared to Survey Sample	152
Table 5.27	Teachers' Views on Role Preparation	152
Table 5.28	Percentage of Teachers who undertook Types of Preparation	152
Table 5.29	Teachers' Rating of Ability to deal with Situations in Shared Learning Environments	154
Table 5.30	Teachers' Level of Agreement with the IPE Definition	154
Table 5.31	Teachers Level of Agreement with Attributes of Shared Learning	154
Table 5.32	Combined Frequencies of Teachers' Scores on Attributes of Shared Learning	163
Table 5.33	Five Categories of Shared Learning Attributes	163

List of Figures

Chapter Three

Figure 3.1 Individual and Shared Priorities 55
Figure 3.2 Framework for Policy Development 57
Figure 3.3 Quality in the NHS 58
Figure 3.4 Priorities for Services for Adults and Children 59
Figure 3.5 Improving Partnerships 60
Figure 3.6 The Paradox of Collaboration 63

Chapter Four

Figure 4.1 Flowchart to Illustrate Stages of Data Collection 93
Figure 4.2 Methods for Data Collection and Analysis 104
Figure 4.3 Framework for Data Analysis 111

Chapter Five

Figure 5.1 Questions for Survey One 114
Figure 5.2 Programmes Validated by the ENB for Teacher Qualification (s) 115
Figure 5.3 ENB Validated Programmes within Teacher Education Centres 117
Figure 5.4 Questions for Survey Two (Part One) 128
Figure 5.5 Questions for Survey Two (Part Two) 137
Figure 5.6 Questions for Survey Three 142

Chapter 6

Figure 6.1 Sources for Qualitative Data 165
Figure 6.2 Continuum of IPE Initiatives in Higher Education 177
Figure 6.3 Driving Forces for Shared Learning Environments 178
Figure 6.4 Beneficial Outcomes of Shared Learning 182
Figure 6.5 Barriers to Shared Learning Environments 182
Figure 6.6 Key Organisation and Management Issues 184
Figure 6.7 Teachers' Values and Beliefs on IPE 187
Figure 6.8 Teachers' Role in Professional Practice 192
Figure 6.9 New Teachers Evaluation of Shared Learning within Teacher Preparation Centres 199
Figure 6.10 Students' Preparation for IPE 203
Figure 6.11 Teachers' Teaching Strategies for IPE 211
Figure 6.12 Attributes of Shared Learning 225

Chapter 7

Figure 7.1 Integrated Learning Model 251

Chapter I

Introduction to Thesis

Introduction to Chapter

This chapter aims to provide an overview of the thesis. The chapter gives the background to the concept of Interprofessional Education (IPE) for health and social care professions. The background policies and implications for health and social care professions are discussed. The chapter concludes with the focus of the thesis.

1.1 Background to IPE as an Innovation

IPE as a concept and new paradigm for professional education has increasingly developed partisanship since the early seventies. The literature worldwide focuses on the obligation of professionals to address collectively the needs of a changing community. The World Health Organization (WHO 1984a) requested professionals to re-address how they work together and suggested that education of professionals should be linked to formulate more productive working relationships. For the past thirty years, the literature has highlighted the problem of inadequate education for professions to provide holistic client care and advocated joint education for these professions. The terms used to describe joint education include interdisciplinary, multiprofessional and interprofessional education. For example, Tope's (1994) intensive literature review, highlighted that interdisciplinary education implied education of different health professional groups. Since the early 1980s, there has been a rapid increase in publications accumulating to thousands of references to interprofessional care, practice and

education. The concept of shared learning was regularly used in earlier research to suggest IPE rather than the construct itself. There is a lack of attention paid to the teaching of these professionals, neither have the views and needs of the teachers been addressed sufficiently (Tope 1994; Jones 1992).

Most European countries have strived to implement the WHO (1984a) objectives through various educational initiatives. A historical account of these initiatives in Europe can be found in the writings of many authors. Tope (1994) examined the literature on integrated and interdisciplinary education from a global perspective. Casto (1994), and Knapp and Associates (1998) give an American perspective. The reported literature identifies many of the advantages and disadvantages of the phenomenon. Similar results are forming a pattern that reflect the value of IPE, but regrettably, highlight the lack of commitment and resources to implement policy effectively. Whilst many success stories are reported, researchers recognise the lack of rigorous research evidence to support any positive impact on client care (Barr et al 1999; Tope 1998). Yet, clients still request greater interprofessional involvement in care (Tope 1999). Two major surveys (Barr & Waterton 1996; Shakespeare et al 1989) have identified numerous interprofessional initiatives. However, many of these are not evaluated nor are the evaluations published (Barr 1996). Barr & Shaw (1995) identified nineteen published evaluations, and more recently Barr et al (1999) reported that few initiatives in the UK met the set criteria for evaluation of programmes as defined by the Cochrane Review Panel. The next section will address the policy background of IPE and the implementation and evaluation of such.

1.2 Policy Background

The development of health and social professions is influenced by education, research, and reassessment of the health and social care requirements in society. The evolution of education for health and social care professionals has been accelerated by changes within the structure and provision of health and social care and the influences of the World Health Organisation (WHO 1985; 1984b).

The consequences of a 'separatist' educational model were succinctly positioned as absence of teamwork, overlapping boundaries, and fragmentation of care provision. An alternative model of care provision, supported by educational initiatives, advertises multiprofessional education as integrated and concurrent learning to develop a skilled group who would communicate and interact collectively within a team. However, the concurrent nature of this education advocates learning that runs parallel rather than in tandem (McCroskey & Einbinder 1998; Clark 1993).

Interprofessional education as a concept supports the notion of collaborative learning and interaction meaning that the group members learn from and about each other (Barr 1994a). Thus, interprofessional education forms the roots of fruitful teamwork that in turn gives added value to health and social care. The consequences of change from a separatist model have huge implications for policy, economics, professions, and ultimately, teachers of health and social care professionals.

Higher education in the UK is provided by a variety of institutions, including Universities, the Open University, and other colleges and institutions of higher education. Primary and secondary school level teachers must hold a first degree and a postgraduate certificate or a Bachelor in Education (BEd.) and qualified teacher status through an approved initial teacher training course. Higher education teachers normally hold a higher degree. Teachers in the health and social care professions are normally qualified practitioners in their own profession. Statutory regulations stipulating a teaching qualification govern the teaching of nurses, midwives and health visitors and until recently physiotherapists. Other teachers of professional education have not been bound by such regulations.

The World Health Organisation (WHO 1973) suggested curriculum components for teacher training for health professionals. These components included sociology of health, curriculum development and educational philosophy. Teaching of health and social care professionals has become an ever-increasing challenge for teachers within practice areas and educational establishments. This challenge is borne out in the expansion of health and social care through a matrix of different organisations and agencies with local and national changes rapidly influencing how the purchasing and provision of this care may alter.

Health and social care has developed to encompass vast fields worldwide that are inclusive of critical care, continuing care, community care and primary care. All of these fields branch across adult, child/family, mental health and learning disability care. The purchasing, provision, policy, education/training,

management and research within these fields will be of concern for teachers of health and social care professionals.

In the context of shared learning collaboration may not always be viewed positively, especially when professions see their freedom to act independently curtailed and when insufficient resources are available to maintain collaborative links. These issues seem even more pertinent within the present changing political context within health care provision (Shaw 1993). The provision of educational programmes is largely dependent on the purchasers and as changes develop, professions may find that their strongest means of survival is through collaboration.

1.3 Implications for Professions

The literature discusses interprofessional education in the context of international, national and local policies, identifying the purpose of IPE and the implications of policy change to the professional education of health and social care professionals. Interprofessional education evolved because the traditional approach to educating health and social care professionals was not creating collaborative practice (Leathard 1994). The changes occurred gradually and variably throughout the UK and were influenced by the evolving nature of educational theory affecting all types of education and training. It would be naive to suggest that political influences did not create a need for change and some would question which forces were stronger, educational theory or political willpower (Barr & Shaw 1995). The policy implications and political influences are discussed in chapter 3.

It appears that the present position of professional status within health and social care and the potential demarcation or dilution of boundaries needs to be addressed in the context of shared learning initiatives. The boundaries between professional groups have traditionally been maintained through claims to specific knowledge and competence to practice individually or as a group. These boundaries are being diluted with the changing focus on health and welfare services, and inter-professional and inter-agency collaboration. Dilution of boundaries is particularly notable in community care.

Reviews of vocational qualifications (NHSE 1995; DES & ED 1991; De Ville 1986) emphasised a need to establish progression routes between vocational and academic education. The establishment of a health care National Training Organisation (NTO) and a Training Organisation for Personal Social Services (TOPSS) was welcomed by the Minister for Health as a means to destroy the 'Berlin Wall' between social care and health care (Dobson 1998a; 1998b).

The introduction of vocational routes into professional education for health and social care called into question the distinctiveness of professions and the ethos of professionalism (Hevey 1992). Dilution of professional boundaries through shared learning cannot be viewed in isolation from the extensive political, economical, educational and cultural implications (Barr 1994b). Conversely, the proposal to open access routes to professional education for an undervalued workforce, and address occupational standards, should create conditions

favourable to multiprofessional and interprofessional education within health and social care (Hevey 1992). Although professions may debate collaboration in education, the need for partnerships in the provision of care is evident.

The need for active partnerships between organisations and individuals in working together to improve health requires multidisciplinary solutions to practice, supported by multidisciplinary education (DOH 1994a; Secretary of State for Health 1992). In addition, the consumers of health care require integrated services, which reflect their needs rather than emphasising professional boundaries (ENB & CCETSW 1992). This supports the need for interprofessional learning through interactive processes. The first ever Statement of Intent shows commitment from the nursing and midwifery profession in developing partnerships (ENB 1995a; DOH 1994a). Education providers are challenged to maximise opportunities for shared learning. It is suggested that these programmes should be student focused and practice led initiatives with more effective modes of delivery (DOH 1994a).

Two major surveys have been undertaken to identify the extent and type of interprofessional initiatives (Barr & Waterton 1996; Shakespeare et al 1989). The extent of interprofessional shared learning in primary health was first surveyed between May 1987 and April 1988 (Horder 1992a). The initial survey identified 695 examples of IPE in Great Britain. These initiatives comprised at least two professional groups in primary care provision. However, half of the programmes were of short duration consisting of one day or less, while ten initiatives lasted twelve weeks or more. The main purpose was to develop practitioners for

teamwork through sharing the same subject content and identifying a common purpose for attendance (Shakespeare et al 1989). The evidence did not suggest a focus on role functions, role boundaries or interaction between professional groups.

A refined criteria was developed to identify initiatives for inclusion in the second survey, 455 collaborative initiatives in the whole of the United Kingdom (UK) were identified. This broader survey of interprofessional learning for primary and secondary care provision did not show an expansion in the number of initiatives but showed an escalation in the composition of professional groups involved in interprofessional education (Barr & Waterton 1996). This increase in the number of professions sharing learning environments has been attributed to the development of flexible pathways through modularised programmes and open learning modes in post-qualifying education, within multi-disciplinary contexts (Barr & Waterton 1996; DOH 1993). However, there are suggestions that modular systems have not facilitated professionals to learn from and about each other (Barr 1994a).

Models of collaboration and shared education may involve a combination of course content (theory and practice), course outcomes, and awards (academic/ professional). Any one of these may offer an independent focus for shared learning (ENB & CCETSW 1995; ENB & CCETSW 1992). Interprofessional education in teacher preparation programmes tends to have the same assessment, award systems and learning outcomes for all disciplines. However, formal shared learning within teacher preparation programmes and in pre and post-registration

education for nurses, midwives and health visitors, takes place mostly within a classroom environment (Mhaolrúnaigh et al 1995).

The implications of shared learning at pre-qualifying and post -qualifying levels are still a matter for exploration (Mhaolrúnaigh et al 1995; Barr 1994b). There is some evidence that teachers and students in pre-qualifying courses in health and social care were extremely in favour of shared learning at all academic levels (Tope 1994). Research findings suggest that interprofessional educational programmes at Master's level focus on interprofessional issues in relation to knowledge and understanding of care delivery, across a range of professions, but do not directly address interprofessional work (Storrie 1992). Clark (1993) suggests that if interprofessional education as an innovation is to develop positively, it needs to be built into educational programmes for health professionals at all levels and at recurring stages so that sufficient time is allowed for individual development and change in behaviour.

Teachers are required, therefore, to keep abreast of policy implications from statutory bodies, government departments and various local authorities. The plethora of reports and documentation based on the teacher's own profession alone, can be challenging to the individual, besides the ever increasing pressure to demonstrate professional competence. Interprofessional education by intent places even greater demands on the teacher.

The concept of interprofessional education is now known in many international arenas and the influx of related literature is clear evidence of this. One of the greatest difficulties and challenges teachers of interprofessional education are confronted with is *interaction*, how to create it, monitor it and sustain it over time to ensure 'shared learning' has occurred for the benefit of health and social care recipients. Unravelling interaction or discourse is also a challenge for the researchers of interprofessional education. Traditionally, gender traits have created stereotypical models for nursing and medicine, which carry with them archaic attitudes and potential conflict between the professions. I am reminded of the huge differences between genders in conversing (Tannen 1992), but the numerous variables that exist between different professionals are daunting. Nevertheless, teachers of health and social care professionals are faced with the reality of facilitating interprofessional learning, when few have expressed specific preparation. Moreover, their role has developed often due to circumstances and is additional, rather than a *specific* role function determined by careful planning.

1.4 Focus of the Thesis

In view of the dearth of research on the role of the teacher and a lack of conceptual definition of IPE, this thesis aims to unravel the parts that culminate and masquerade as IPE and re-structure the whole within a new framework. The fundamental mission of any educational initiative is teaching and learning, consequently the focal theory for this thesis examines and analyses the facets of teaching and learning in interprofessional education. In so doing, a conceptual framework is developed that is seen to encompass interprofessional education and interprofessional practice. The methods used to unravel the parts are multiple,

using the teachers as a focus for data production. The teachers were chosen as they are generally seen to possess the intellectual knowledge of educational theory and act as facilitators of the learning milieu. The data was collected over a period dating between 1994-1997.

1.4.1 Research Statement

The narrative of interprofessional education has been used over the past two decades as a way of determining the theory and practice of health and social care professionals. Its value has been grounded in the notion that if professionals learn together and about each other, they are more likely to function effectively and collaboratively in practice situations. This hypothesis is a priori; however, the evidence from the clients' perspective does not support the hypothesis (Tope 1998). Researchers report a similar finding around the concept of interprofessional education, however, there is a lack of clarity and little evidence that the phenomena under investigation are one and the same thing. This thesis therefore, formulates and. investigates the hypothesis that *interprofessional education is less than the sum of its parts,* as reported in the literature. The role of the teacher in relation to interprofessional education has not been defined. Data production and analysis to support this thesis will address the perceptions of teachers. To support the thesis, the author will draw on educational theory, organisational theory and policy analysis theory. The researcher recognises the abundance of literature surrounding the problem. Through fracturing the phenomena and re-structuring the concepts, the thesis develops a conceptual framework for future work.

Chapter 2

The Concept of Interprofessional Education

Introduction to Chapter

This chapter discusses the concepts underpinning IPE. The traditional way of educating health and social care professionals is reviewed in relation to the current proposal for interprofessional education. The implications for teaching and learning are discussed. The chapter concludes with a discussion on building a conceptual framework for IPE.

2.1 Defining Terminology

There are many and varied constructs that constitute IPE but the main ingredient or core concept is shared learning. Researchers have addressed the terminology quagmire but there is no evidence of reported work that clearly unravels the web to state empirically that IPE constitutes some or all of the stated constructs.

It is clear from the literature that varied definitions are applied to IPE. All state a purpose or many purposes for this approach to teaching and learning. The focus varies and often recognises the local needs of the organising establishment(s). Some of these definitions aim to encompass aims and objectives for learning, outcomes for the learners and the community who are exposed to the professionals involved in the process. Horder's (1993) view focuses on the

educational aims and the environment in which the initiative is implemented. He states that interprofessional education has two meanings:

> *At one level, it is understood to be directly concerned with service development and is often undertaken at the workplace. At the other, it means those forms of higher education which are necessary to provide a wide view and which enable professions to gain a deeper understanding of the organisation in which they work and their relationship with other professionals* (Horder 1993 p71).

The Centre for the Advancement of Interprofessional Education (CAIPE 1995) reviewed the literature and classified the principles of IPE as the following:

- Works to improve the quality of care
- Focuses on the needs of service users and carers
- Involves service users and carers
- Promotes interprofessional collaboration
- Encourages professions to learn with, from and about one another
- Enhances practice within professions
- Respects the integrity and contribution of each profession
- Increases professional satisfaction

These principles suggest that management support is required, that teaching and learning focuses on equipping the practitioners of health and social care with collaborative skills and the ultimate goal is to create effective and efficient services for clients.

Intertwining terms that are distinct but relevant to the structure and processes of education for professionals complicates the terminology surrounding IPE. These terms relate to the type and nature of education such as multiprofessional, interprofessonal; the disciplines or professions involved, such as interdisciplinary, multidisciplinary; the nature of learning, such as shared learning, group learning; and the anticipated outcomes, such as teamwork and collaborative practice. The

compilation of groups within a shared learning environment is frequently referred to as interprofessional or multidisciplinary education.

The term 'discipline' usually encompasses all, or some, of the disciplines allied to medicine including the health and social care professions. Terms such as interprofessional learning, interdisciplinary learning, intradisciplinary learning, multidisciplinary learning, transdisciplinary learning, mutual learning, dual learning, and joint training are all used in the literature and usually signify the sharing of experiences between groups and/or individuals. There are different schools of thought implicit in the use of such terms. For example, if the direct translation is used 'inter' means between, 'intra' means within, 'multi' is many, 'trans' refers to across. Interprofessional is sometimes viewed as between two disciplines only, and in contrast to 'multiprofessional'. In academic terms, multidisciplinary learning can refer to various academic disciplines outside the boundaries of health and welfare, while multiprofessional and interprofessional learning can be viewed within the boundaries of health and welfare professions within a shared context (Leathard 1994).

Clark (1993) proposes that confusion is created not only by these various definitions but also through diverse settings, contexts, and levels in which the nomenclature of 'shared learning' is applied, and questions whether sufficient attention to is given to these variables.

The ENB (1990) suggested that shared learning is a planned approach or a strategy within a curriculum leading to shared knowledge and experience

between groups. The Current Index to Journals in Education cites shared learning as 'partnerships in education' and defines it as:

> *Collaborative arrangements and endeavours between and among schools and other entities (corporate enterprises, community agencies student/parent/citizen groups, colleges, other schools, individuals etc.) designed to share resources, achieve common goals and foster educational achievement, improvement, and reform* (CIJE 1995 p325).

This lack of clarity in definition of terms relating to shared learning initiatives produces both a problem and challenge to researchers exploring shared learning, and is not only confined to the available sources in the English literature. Clark (1993) addressed the nomenclature in America within the realms of education in care of the elderly and suggested that shared learning may be differentiated in the following way:

uni-disciplinary - students are all from the same discipline or profession and the aim of educational programmes is to emphasise mastery of a specific body of knowledge and skills attainment is characteristic of that profession.

multi-disciplinary - many different perspectives afforded by several different academic 'disciplines' however, sharing in this educational setting is probably more incidental than planned but running on parallel tracks.

Inter-disciplinary or interprofessional - these terms are often used interchangeably and suggest that sharing commonalties in lines of communication are the norm between participants and that participants can integrate and modify their thought processes. It is suggested that such programmes should be co-taught by a team of teachers to provide team-based role models for participants.

The multiplicity of terms used to described shared learning is an important consideration, for lack of consistency in use may result in lack of consistency in interpretation when examining a range of differing professional perspectives. However, clear definition is not easy to sustain as there is difficulty in finding common meaning in the range of words and terms used to describe shared learning (Pietroni 1992; Mhaolrúnaigh et al 1995). A valuable contribution in the context of defining shared learning was made by Shaw (1994a) who made a distinction between interactive programmes which utilised the past experiences and background knowledge of the professionals, and those programmes which trained different professions about the same topic. As a result of a survey the argument was forwarded that only programmes that include interactive learning should be properly termed shared learning (Shaw 1994a).

Interprofessional co-operation or shared learning within disciplines suggests that language similarities/differences and therefore good communication is the initial key to success. Pietroni (1992) illustrates how communication between health care professionals is hindered by diversity of language. He describes 11 different sub-sets that are in use such as: medical/molecular/material; social/cultural/epidemiological; psychological/psychomatic/psychoanalytical; prevention/promotion/education, thus suggesting barriers to collaboration and sharing. This work indicates that links between language, thought culture and ideology should be addressed within health care professions if sharing and interprofessional care boundaries are crossed.

Linked with the issue of language there is a need for evaluation of the benefits of interprofessional training in communication skills. Steps have been taken to facilitate collaboration and communication through common patient/client records (Tait 1992), group practices, and joint educational sessions. The national survey of interprofessional learning (Horder 1992b) indicated that in 1988 there was a high number of collaborative programmes for health professionals, yet the processes in communication and shared learning are not always addressed. This illustrates the point that learning together is one thing, learning from and about each other is quite another (Barr 1992; Thurgood 1992a; 1992b).

Research studies suggest that participants in shared learning experiences should have a greater appreciation of expertise in their own and other professions and are able to break down unhelpful stereotypes through identification of shared skills and values. This shared appreciation could lead to greater understanding and fruitful working relationships provided the educational initiatives are carefully planned (Clark 1993).

The multiprofessional group can form numerous combinations for sharing educational initiatives. There are several calls for the involvement of the clients in such educational endeavours who will not necessarily be professionals, therefore how can the phenomena be consistent for evaluative purposes? The common sense approach to this question might be that we need to focus on what each individual profession can contribute. Some of the issues surrounding professionalism are addressed in the next section.

2.2 Traditional Professional Education versus IPE

The following section will address the traditional nature of education for health and social care professionals, the reasons for change and the relationship of the traditional model to the proposed new model of interprofessional education. It is important that the reader is mindful that the teacher's role in health and social care professional education will involve the 18+ age group and therefore draws on adult education theory and the management of learning for older age groups. Some professional groups have been traditionally educated within Higher Education (HE) institutions. The movement of professions complementing medicine into HE has been more recent.

Historically a division is evident, and to an extent exists today, between the health and social care sectors (Hugman 1995). Both groups viewed themselves as quite distinct from each other, and from another tier of professionals, 'paramedical professions', often referred to as the abbreviated version Pams' or professions allied to medicine', or more recently known as professions 'complementary to medicine'. Traditionally, health care professionals were trained and/or educated within a 'separatist' model of education. This meant that professionals were isolated from each other within the theoretical component of curricula. Learning in, and through workplace experience, usually transpired on an informal basis only. In addition, the teaching of professionals was solely the responsibility of their professional body and educational institution (England 1986).

The problem of status and hierarchy is evident through the history of the caring professions (Hugman 1991). Medicine has assumed higher status than other professions or disciplines. This has led to the struggle for professionalism by some caring professions (Broaden 1997). A typical example of how a profession is viewed differently can be seen in the contrast between medicine and nursing. Traditionally both groups were taught in a competitive fashion, where assessment of knowledge, skills and attitudes were partly the responsibility of role models in practical settings. Contrary to medicine, the nursing community had little or no opportunity for debate on knowledge foundations or argue in defence of their uniqueness:

> *The unique body of knowledge of a profession provides the 'intellectual authority' for practice. Combined 'theoretical and practical' authority gives rise to the domain of enquiry and practice of the professional and provides the boundaries and rules for practitioners' behaviour as professionals* (Casto & Juliá 1994 p44).

The fight for higher or equal status with medicine caused a competitive edge between social care professions and other professions/disciplines allied to medicine (Hugman 1991). This competition for status recognition was often covert or hidden. Nurse education and others relied heavily on the medical profession to teach the curriculum, especially the biological and behavioural sciences, and often for approval of status within the work environment. This was a consequence of the debate for recognition of professional status. Professional status, according to Larson (1977), has to meet with certain criteria:

- A social market for skills
- Some exclusiveness of these skills
- An educational component
- Some status gained for its members
- Some auto-regulation or governing organisation

Medicine, in comparison to other health and social care bodies, aptly adopted these criteria (Turner 1992). Moreover, recruitment and selection to medicine and allied professions was commonly known to fit a social category system. This in turn generally reflected the level of education, the type of education and educational achievement within the boundaries of class distinction (Boaden 1997). To some extent this continues today, albeit, many of the traditional values are absent in the provision of education and policy formation. Ideologically, today's policy predicts an even chance for school leavers with similar educational achievements, to enter a profession or discipline.

Jarvis (1983) distinguishes between 'status professions' and 'occupational professions' suggesting that the latter are engaged in the process of professionalism. He concludes that a professional must have mastery of the knowledge underpinning the profession and be competent to apply it effectively. Dunlop et al (1999) state that instead of trying to define a profession it is more important to prescribe to the ideology of professionalisation. In so doing, the substantive body of knowledge must be identified and applied. Strong aspirations towards professionalism and use of professional language can be part of a bid to achieve or maintain power (Hugman 1991). Thompson (2000) looks at professionalism more positively to mean a commitment to high standards, values and principles to guide practice, a degree of autonomy and responsibility and a formal knowledge to maximise effectiveness.

Over time, the nursing community and other health and social care professions have taken affirmative action towards professionalism as described by Thompson (2000), and combat the image of inferior status to medicine (Boaden 1997).

The comparison of professional groups from a historical perspective paints a picture of individual professions following a career and work pathway separately, but with daily interaction within the work context. Ownership of status and role identification was of the utmost importance. This individualistic professional model developed value systems and specialist languages known and owned by group members. Turner concludes that:

> *Postmodernism exposes the fact that monodisciplines are federations of thematic components which are held together by the pressure of professional authority and the vested interests of their practitioners* (Turner 1992 p147).

Hugman (1991) views the demarcation of caring professions as competitive and a disadvantage to themselves and their clients. The consequences of the split between professions and disciplines in health and social care were borne out in their working relationships. Power and ownership dictated role identity and role functions, and led to discontent in the workforce (White 1989). The proposal of IPE challenged this ownership and questioned the role identity of all professionals involved. Evidence in support of change came from political, health and social care, and in particular through discontented clients and public avenues.

Any analysis of the past must address the grey areas and, of course, there is an element of polarity in some of the previous discussion. In the workplace where interaction between professionals is normal and natural the boundaries become

diluted and common values and goals develop. Interprofessional education for health and social care professionals at both pre and post qualifying levels acknowledges areas of overlap in knowledge skills and attitudes required by all groups. Recognition of common ground isolates the traditional way of educating these groups.

The 'new model' of education for health professionals/disciplines is based on the assumption that if they learn together they will work together more effectively (Barr 1994a). Therefore, the structure of educational programmes and the process of sharing should influence the educational outcomes. Interprofessional education requires new learning through dialogue, support and collaboration, leading to new thinking. It follows that the teacher as facilitator requires a repertoire of skills to co-ordinate the learning milieu through interactive processes. Nurse and midwifery education took the lead in preparing teachers for their role through credited educational programmes (UKCC 2000; 1988).

2.2.1 Intellectual Property of Professions

'Knowledge' is the intellectual property of any profession and medicine has traditionally held the status of a profession suggesting that the members of this profession have a common language through 'normal science' (Kuhn 1970). As members of a profession, the teachers are fluent in the 'normal discourse' of the community (Bruffee 1993). Contrary to this, there are other health and social care members who have to a lesser degree developed their intellectual property and subsequently have not yet reached a level to support normal discourse between the members such as nursing. This type of discourse might be equated to non-

standard discourse as described by Bruffee (1993). The paradigms of a profession, foundational knowledge, or intellectual property dictate to an extent, the type of discourse used.

Medicine has traditionally relied on a positivist approach to knowledge development. Contrary to medicine, other professions and disciplines rely more heavily on generating theory to develop a body of knowledge (Turner 1992). This claim is not to undervalue the knowledge acquired through qualitative research methods but to highlight the difference in values and beliefs posed by professions within the health and social care sectors. The result can create a dichotomy between professionals and a lack of common discourse. If knowledge is *'intrinsically the common property of a group or else nothing at all'*, (Kuhn 1970 p210), it begs the question of the need for a common language between health and social care professions.

Dewey (1963 p18) succinctly stated that traditional education and training demanded *'docility, receptivity, and obedience'*. The educational philosophy of the traditional model perpetuated the notion of training versus education. For IPE the teacher has to adopt the facilitator style where the student and group are centre focus in the learning process. The traditional role of the teacher is one where knowledge is an entity to impart to students and the teacher is an 'expert' in the foundational knowledge or cognitive understanding of knowledge (Bruffee 1993). Using Kuhn's theory of understanding knowledge as "nonfoundational social construction", Bruffee examined the consequences for collaborative learning.

> *Collaborative learning is a reacculturative process that helps students become members of knowledge communities whose common property is different from the common property of the knowledge communities they already belong to* (Bruffee 1993 p3).

One has therefore to acquire the specific characteristics of the community members, and most importantly, fluency in the language of the group. The position of intellectual judgement shifts from the teacher to the social relationships of the learning community when collaborative learning occurs (Bruffee 1993). Teachers can facilitate the 'crossing of boundaries' for students by creating conditions that develop self-direction and interdependence (Dewey 1963). However, some evidence suggests developing interdependence for students at pre-qualifying level has its own problems as their learning styles tend to demand high teacher contact and input and concrete cognitive thinking (Wall 1994).

Bruffee (1993) proposes that learning occurs *among* people, not *between* people, thereby overruling traditional notions of the authority of knowledge, authority of teachers, and the very nature and authority of colleges and universities. Bruffee focused on learning between disciplines from a collaborative approach. In applying this collaborative approach to interprofessional education, it means that:

- different communities of health and social care can learn collaboratively
- learning takes on a new form of interaction that develops a 'new community' knowledge
- teaching of interprofessional education has to cross 'community boundaries' and facilitate 'new knowledge'
- students have to develop interdependence to function as a' new group' of professionals with new knowledge and fluency.

In interprofessional education, the individual has two transitions to make. Firstly, they need to reflect and recognise their own background in relation to their own profession, and secondly, reflect and recognise their own profession in relation to the new others within the group. The task for the teacher in collaborative learning is to develop fluency in the language of their own profession and have the ability to translate the language of one community into the language of another. The teaching approaches should enable the group to develop negotiative, collaborative and transition skills. Ultimately this means that the teachers must rethink what is required in preparation to teach and reflect on what they do when they teach:

> *For teachers to adapt this type of teaching may require a depth of change that is difficult if not impossible to accomplish individually. Collaborative learning is most likely to fulfil its promise if the faculty or whole institutions build transitional conversational units committed to this painful, painstaking collaborative talking-through* (Bruffee, 1993 p79).

This means profound discourse on interprofessional knowledge. Interprofessional knowledge involves:

> . *the sum total of what professionals in different specialised areas know and know how to do. Collectively, these differing bodies of expertise are brought together to bear on a common problem that requires more than one expert perspective* (Knapp & Associates 1998 p74).

This view has several implications in the selection of content for IPE, which fall between common knowledge and distinct knowledge. Knapp and Associates (1998) note that the nature of IPE knowledge is fluid and situation specific, rather than fixed and therefore requires constant negotiation between participants. IPE in teacher preparation courses has been given minimal acknowledgement in the literature. Tope (1994), however, found that teachers and students in pre-

qualifying courses in health and social care were extremely in favour of shared learning at all academic levels.

2.3 Implications for Teaching and Learning

Shared learning initiatives at both pre and post qualifying levels have been addressed in Britain (Miller et al 1999; Howkins & Allison 1997; Harbinson 1994; Watts 1988). There is some debate as to the appropriateness of shared learning at pre-qualifying level (Barr 1994a). One of the problems addresses the need for professional socialisation and identification prior to gaining understanding of the effects of such on other professions.

For some time there has been a joint learning programme on learning difficulties and social work. The early programme met with considerable debate regarding the requirements for each professional registration. These initiatives were overtaken by the developments in nurse education through Project 2000, and in the development of the Diploma for Social Work. There are joint degree courses for learning difficulties and social work (Barr 1994b).

Stanford & Yelloly (1994) found that students from nursing and social work valued an interprofessional educational model at post-qualifying level. However, the project drew heavily on the goodwill of individuals and the cost implications were high. Shared learning initiatives at Masters degree level have been explored by Leathard (1992), who emphasises that the main aim is to equip health care professionals with research skills and critical thinking skills within interprofessional team approaches. It has been suggested that the strategies now being devised on Masters programmes enable students to highlight their different

professional perceptions and give opportunities for both professional and personal re-appraisal. These initiatives deserve to be closely followed and evaluated (Storrie 1992). A present, there is insufficient information available to state confidently the benefits of shared learning or to identify models of good practice on which to base future planning (Jones 1992).

Interprofessional education in primary health in Britain has been discussed since the early 1980s. The results of interviews with 50 key personnel nationally, gives a focus on shared learning occurrences in the training of health professionals, educational initiatives, stages in education, and facilitation and monitoring of shared learning (Barr 1994a). The results of a survey by Ian Shaw (1994a) on shared learning initiatives gives a valuable contribution to the context of shared learning as interactive learning. A distinction was made between interactive courses, which utilised the experiences and background knowledge of the professionals, and those courses, which trained different professions about the same topic. The argument is advanced that only courses that include interactive learning should be properly termed shared learning (Shaw 1994a). It is suggested that evaluations of shared learning differ in their approach and rigour, which causes difficulties in comparison of results (Barr & Shaw 1995).

Developmental responses to the research into shared learning can be seen in several initiatives. The Nursing, Midwifery and Health Visiting Education Forum (DOH 1994a) identified broad objectives for stakeholders, educators and quality managers. These objectives can be classified as a blueprint for interprofessional and multidisciplinary shared learning in which education providers are

challenged to maximise opportunities for shared learning. It is suggested that these programmes should be student focused and practice led initiatives with more effective modes of delivery. The ENB (1995a) responded to this 'Statement of Intent' through a declaration of commitment to collaboration and sharing within a multidisciplinary arena.

Several other programmes focusing on developing skills in clinical practice have incorporated a shared learning approach, in particular in the care of the elderly and primary health care (Runciman 1989; Hutt 1986). There is an assumption that interprofessional learning in community care will improve patient care through acknowledging role relationships and sharing theoretical aspects. However, insufficient evidence is available to suggest whether shared learning outcomes are sufficient evidence or even necessary to build interdisciplinary understanding.

The outcomes of shared learning cited by Jones (1992) included greater teamwork in practice and reduction in role conflict in interprofessional groups. The nature and purpose of teamwork and the factors that facilitate or hinder effective results are discussed in the literature (Engel 1994; Pritchard & Pritchard 1994).

Some guidelines for 'good practice' have been suggested, with exploration, identification (Pietroni 1992) and standardisation (Clark 1993) of nomenclature adopted to facilitate successful outcomes of shared experiences. This has been addressed by joint initiatives between the ENB and CCETSW (1992) in a

proposal for possible models of sharing. These models offer an independent focus for shared learning as follows:

- Sharing of theory and/or practice elements within separate courses with distinct outcomes and awards
- Sharing of workplace practice and credits awarded on professional development
- Theory and practice elements of an identified core with a number of shared outcomes but with separate awards
- All aspects of course including outcomes and same awards.

Clark (1993) suggests that if interdisciplinary education as an innovation is to develop positively, it needs to be built into educational programmes for health professionals at all levels and at recurring stages so that sufficient time is allowed for individual development and change in behaviour:

> *Simply 'putting people together' in groups representing many disciplines does not necessarily guarantee the development of a shared level of understanding, rather, it may simply reinforce the barriers that exist for the very purpose of defining different professions* (Clark 1993 p218).

Educational planners also need to carefully address the objectives, processes, and the use of learning materials in shared learning programmes. This demands institutional support and awareness of the potential repercussions of shared initiatives (Clark 1993). Within a well planned and sophisticated framework, interprofessional education may be one way to ensure that professional skills are not lost within the current changes in the structure, provision and delivery of education (Shaw 1993). Modularised programmes, competency-based education

and open learning modes have accelerated shared learning environments. However, the present research literature suggests that modular systems have not facilitated professionals to learn from and about each other (Barr 1994b).

Knapp and Associates (1998) reported similar developments in the USA in fostering effective IPE to support health and social care delivery. The barriers to collaboration and partnerships were reported as:

- Rivalry between professions
- Levels of preparation varied
- Qualifications and status varied
- Requirements for regulation and standards of professional education differed.

In the USA, partnerships between National bodies (Federal Bureau of Health Professions/ Health Resources and Services Administration and The Institute for Healthcare Improvement) were established in 1995. The purpose of this was to build and improve community-based education. Four pilot centres were established, which were later extended to add another six centres. Lessons learnt from the research suggested that careful planning is essential and that communication between different bodies was lacking, however, the educators involved had developed and become leaders for interprofessional education. The University of Missouri has developed partnerships with eight colleges to plan, implement, monitor and evaluate interprofessional education using interactive learning and competency based learning (McCroskey & Einbinder 1998).

Tope (1998) reviewed publications in the UK written by and on behalf of clients themselves. This review was prompted by the question are patients active or passive recipients of care? Domination by professions, mistrust and difficulty in

securing continuity of care were frequently reported, albeit many recipients were sufficiently content with their care. Those recipients who lodged complaints justified their decision based on:

> *A breakdown in communication between and a lack of collaboration within the health professionals themselves, or between the health and social care professions* (Tope 1998 p3).

The findings also suggest that team meetings are rare in some institutions and discharge planning often haphazard. The study resurrected the dichotomy in clients' rights and choices and the professionals' perceptions of needs of clients. In addition, the results suggest that the hub of interprofessional collaboration is eroded as, regardless of the care sector, the following problems arose; qualifications of workforce to meet the task lack of continuity, and lack of participation in care planning. The voice of the user of services is often the least influential and often overlooked. As a result of these disturbing findings for the future of interprofessional practice, Tope called for the development of core standards and interprofessional protocols. The latter must be accepted, owned and utilised by every profession. The need for visionary interprofessional education to achieve these outcomes was reinforced (Tope 1998).

2.3.1 Models of Teaching, Models of Learning

Traditionally the teacher of a discipline presumed the role of a leader where knowledge was imparted as a branch of instruction with a system of rules of conduct. Training meant obedience and a 'way of life'. The students were expected to conform to the norms of the group within a discipline and skills were required to engage in the occupation as a paid member within the discipline. Dewey (1963 p18) succinctly stated that traditional education and training

demanded *'docility, receptivity, and obedience'*. The educational philosophy of the traditional model perpetuated the notion of training versus education. For IPE the teacher has to adopt the facilitator style where the student and group are centre focus in the learning process. The traditional model demonstrates some resemblance to competitive learning.

Competitive learning suggests that there is no sharing or productivity as a collective process between members of the learning milieu. This type or form of learning equates to Bruffee's (1993) phenomena of foundational conventions that govern the classroom environment of traditional colleges and universities. The teacher is the *authority* and there is *no recognised validly institutionalised, productive relationship among students* (Bruffee 1993 p66).

The type of teaching applied to competitive learning may be compared to the traditional lecture conventions and recitation conventions. That is a milieu whereby talk and performance is either by the teacher in the form of lecture or the teacher observing the students' reciting their learnt knowledge. However, to view competitive learning as such is to reinforce the Either-OR philosophy espoused by Dewey (1963) and ignores the 'situation' and social element of a learning encounter. Dewey recognised that the situation in which individuals are involved will equally determine the control of individual actions.

> *For even in a competitive game there is a certain kind of participation, of sharing in a common experience* (Dewey 1963 p53).

Dissatisfaction with and attempts to change from the traditional ways of teaching and competitive learning are widely reported. However, Bruffee (1993) pessimistically declares that these attempts to change are doomed to fail as:

> *The fundamental 'foundational assumptions' about the nature and authority of knowledge remain unquestioned* (Bruffee 1993 p 69).

In addition, Bruffee describes educational innovation of the sixties in terms of opposing polarity, 'inner-outer polarity of the foundational understanding of knowledge'. These polar opposites reflect the objective positivist or behaviourist psychological paradigm where instruction dominates, and the opposing subjective Rogerarian philosophy of freedom to learn. Both polarities intend to develop students' knowledge of subject matter. The philosophy of *freedom to learn* could be viewed as transition to psychological and organisation theory on group learning and learning organisations.

Like many epistemological polarities, educational theories may be viewed as mechanisms of control or non control. When objective approaches are used the teacher ultimately regains control, whereas in the subjectivist paradigm the learner is awarded through self-directed efforts and can control or not control their own educational destiny. For many of those who fail to cope with freedom to learn without guidance they revert to the mores of traditional education which include, *plodding acquiescence, cut-throat competition, self-destruction, rebellion, or withdrawal* (Bruffee 1993 p70).

Competitive learning within interprofessional education is a contradiction if education for health and social care professionals aims to achieve the ultimate goal of interactive teams. Since the structures within which interprofessional education is currently delivered are forced to sustain competition as a mechanism for survival, these teams need to have a collective competitive edge purely to

function within the market forces. Interprofessional education without competition may therefore appear paradoxical.

Concurrent learning as a distinct concept means that learners are co-existing while experiencing learning. Such was the case in some traditional establishments that offered education for health and social care professionals. The increase in mixed groups was accelerated through the movement of mainstream education into Higher Education establishments. Within concurrent learning, groups of health and social care professionals shared the learning environment, but the learning process remained mostly individualistic rather than group focused. Goals may equally be individualistic rather than group focused, although interaction and dialogue between group members will occur, sometimes formally, for example, seminar presentations, but mostly informally outside the classroom environment. Thus the style of interpersonal relationships may be competitive, confrontational or collegial, rather than consensus reaching (Chang & Simpson 1997). Concurrent learning is customary in interprofessional education environments.

The significant difference between collaborative learning and concurrent learning, according to Chang & Simpson, is the interpersonal dimension. In collaborative learning a group of people share common goals as opposed to individualistic goals in concurrent learning. Collaborative learning is an environment in which each person attempts to be a coherent part of a whole, synthesising with one another a shared understanding of values as well as facts. The personal behaviours required of each person in such a setting are not

necessarily intuitive or natural, and it is not uncommon for collaborative learning to be mediated and orchestrated (Chang & Simpson 1997).

> *This distinction may appear to be based only on the difference between having a stated objective for the peer interaction or not, but it is more than that. For a group of persons to be oriented to the Group-as -Focus requires an adoption of common goals, values and culture that are coherent and persist over time* (Chang & Simpson 1997 p8-9).

Chang & Simpson (1997) present a useful paradigm for modelling the processes in individual and group learning, referred to as *The Circle of Learning*. The model represents a combination of two dimensions called 'Activity-Orientation', meaning whether the learner's activity is by oneself or with peers and whether the learning process is focused or oriented towards the individual or group. Four distinct learning categories are described as; lectures, individual learning (self-study), concurrent learning and collaborative learning. This model offers additional ways of perceiving learning by oneself or within a group through the multidimensional attributes of the model which are portrayed as; the interpersonal dimension, the learning environment, the knowledge content, technology support and the sociological dimension. It is noteworthy that the model uses lectures and self-study to reflect modes of learning in preference to individual learning alone. According to Chang & Simpson (1997), concurrent learning may be competitive in nature but it could be argued that competitive learning demands a category in its own right and may transcend all categories. As a result, we may recognise four learning categories: individual, competitive, concurrent and collaborative.

Reflection on practice is commonly considered as a mode of learning. Howkins & Allison (1997) show how genograms were used to create shared reflection on

practical problems and suggests that the facilitator of the process needs preparation in-group debriefing and group reflection. Equally, the students within a multidisciplinary learning ethos need to be in control of their own learning and given time to become acquainted.

Gill & Ling (1995) have contributed to the development of conceptual frameworks for research. The researchers proposed five differing models of interprofessional shared learning:

1. The traditional model in which professionals learn separately about each others' roles
2. The reformed model which focuses on shared content within a common core structure
3. The reformed autonomous model focuses on the process of shared learning but is not role specific
4. The convergent model focuses on both the content and process of learning
5. The specific focus model is directly concerned with professionals working together and aims to enhance their knowledge and skills in a specific aspect of their role.

The focus on interaction is fundamental to the potential outcomes of these models and the indicators are that the structure of these models will vary along with various levels of interaction and reflection. The findings suggest that there is still an issue regarding the type of shared learning which is happening within these environments.

Teachers within health and social care have traditionally been exposed to competitive learning environments within the 'separatist' framework for

education. The evolution of structural change resulted in concurrent and collaborative learning environments. If interprofessional education is to advance and illuminate learning experiences, both teachers and researchers need to consider the structure, processes and outcomes of group learning. Group learning suggests that there are at least three essential ingredients within the group: interdependence, participatory and goal focused elements (Cohen 1994).

In addition, group learning has three interrelated elements: developmental phases, learning processes and types of learning (Dechant et al 1993). The developmental phases need to address the stages and complexity of group dynamics and group learning and the role of the teacher as facilitator of group learning. Ultimately the developmental phases and the types of learning will reflect the learning processes and outcomes. If interaction and dialogue are core components, group learning constitutes at least three facets, individuals in the groups, teacher with individuals in the group and teacher with the group. There is a need to investigate these and other variables in group learning if we are to define what we mean by interprofessional and collaborative learning.

The evidence to date suggests that genuine collaborative learning environments are exceptional rather than commonplace (Mhaolrúnaigh et al 1995). If shared learning is to develop the teachers' skills in facilitating the same, perhaps they need to be exposed to such models in more depth. This is particularly so when facilitating groups in which there are minority groups who, the evidence suggests, have needs that they feel are not always met in shared learning environments.

There is an obvious need to question the teachers' role and preparation in greater depth as these individuals are already coping with such environments.

Johnson et al's (1991) definition of cooperative learning can be compared with the efforts made to identify interprofessional learning. To be co-operative a group must have 'a positive interdependence', promote each other's learning, use 'interpersonal' and small group skills, hold individual's in the group accountable for their share of the work, and process as a group how effectively members work together. The authors emphasise that co-operative learning does not take place automatically when students are assigned group work. On the contrary, the role of the teacher in structuring the learning group is paramount. Furthermore, the institution must display a team-based structure as opposed to a competitive and individualistic composition.

Johnson et al (1991) in their review of the literature found that over 600 studies over 90 years have been conducted comparing the effectiveness of cooperative, competitive, and individualistic efforts. They concluded from the review that far more is known about cooperative learning than most other aspects of education. This does not suggest that it is an easy option, on the contrary, it can place greater obligations on the teacher. The conceptual framework incorporates expectation-states theory and the theory of cooperation and competition derived from Lewin's (1948) field theory.

Cooperative learning groups can be used to teach specific content (formal cooperative learning groups), to ensure active cognitive processing of information

during a lecture (informal cooperative learning groups), and to provide long-term support and assistance for academic progress (cooperative based groups) (Johnson et al 1991). When all three are combined they can form a structure for learning within the institution.

The type of interdependence structured among the group determines how they interact, which in turn largely determines the learning outcomes. Thus cooperative structures create 'promotive interaction', 'oppositional interaction' occurs with competitive learning, while individualistic learning structures will bare no interaction (Johnson et al 1991). The patterns of interaction can be subsumed within three broad and interrelated outcomes: *effort exerted to achieve, quality of relationships among participants, and participants' psychological adjustment and social competence* (Johnson et al 1991 p29).

There are several practical obstacles to developing interprofessional group learning, such as modular systems that may or may not have consistency within the group members, the financial implications for universities in the use of resources for small group work, and the added difficulty of finding time in the ever increasing curricula. Gilbert et al (2000) developed tactics to combat these difficulties. Team building for interprofessional education was developed using simulation and case studies. The aim was to facilitate interprofessional groups to identify common ground and value and utilise the differences between the members. The piloting of this work continues with positive feedback from all of those involved.

2.4 Building a Conceptual Framework for IPE

Few studies of British origin were available to form a conceptual framework for IPE or give added -value to theorising a classification of IPE. The WHO (1988) document *Learning to Work Together for Health* gave steps to take when designing any interdisciplinary learning programme but refrained from identifying a curriculum model. Jones (1992) highlighted areas for concern that clustered around teaching and learning strategies, teacher and student preparation and outcomes of shared learning. Tope (1994) used the term interdisciplinary to denote learning between and among professionals at pre-qualifying level. Tope made a significant contribution to the topic by using two particular models to develop a conceptual framework for her work. These were Milio's (1979) and Leininger's (1971) conceptual models.

Tope (1994) concluded that there were realistic possibilities of using these models for the development of a core curriculum. Tope's (1994) analysis of Leininger's (1971) model was that it was the most illuminating alternative curriculum for health professionals experiencing traditional separate education.

Leininger (1971) took an anthropological stance in reviewing the health and supportive educational systems in America at that time. The *Stratified Pyramid Model* depicted the hierarchical nature of professions with physicians at the apex of the pyramid. She proposed an interdisciplinary *oval* model or *Interdisciplinary Health Team Model* to include consumer involvement:

> *This nonstratified conceptualised model facilitates interdisciplinary group sharing and participation by recognising the value of many disciplines and their contributions to patient care.... The leader is chosen because of*

his objective attitude, genuine interest, and respect for the contributions of all members. (Leininger 1971 p789)

This model represented openness in communication across disciplines with an educational system that was more cost-effective than a *linear-isolated model* on which traditional educational programmes were based. The alternative to isolated educational systems was Leininger's (1971) *Interdisciplinary Cone Model.* The philosophy underpinning this model was based on a need to reduce interprofessional rivalry and competitiveness. Students at pre-qualifying level should have the opportunity to *learn together through an agreed upon and planned interdisciplinary health science curriculum* (Leininger 1971 p790).

The proposed outcomes of the *Interdisciplinary Cone Model* were to develop a body of common interdisciplinary knowledge and a refinement of specialised knowledge domains through socialisation and role identity. There were several related propositions such as that students would have the opportunity to change career pathways if they desired to do so. Equality between professions was a focus of curriculum design. Clustering of specialist interests through planned programmes was recognised. Other disciplines from within the general university community could equally avail themselves of the 'opting in' 'opting out' framework (Leininger 1971). Tope (1994) concluded that these propositions were ideal but would equally be an administrative nightmare.

Leininger (1971) was authentic in portraying a model that holds some of the principles of modularisation in university programmes today. She was mindful of some changes required in the role of the teacher, an element not found in Milio's

(1979) model. Leininger proposed that the group leader or teacher should maintain an equal focus on each discipline and not slant discussions towards any one particular discipline.

Milio's (1979) model emphasised a need to move towards health promotion and prevention of illness using a holistic interdisciplinary model. She proposed that core content of curricula should be based on a systems framework for decision making. This process took a cyclic approach to throughput, input and output at national, regional, local, organisational and individual levels. The model was inclusive of other significant health personnel and consumer representation and not confined to professional education with intentions that:

> *A shared basis of knowledge and a shared perspective of what promotes and damages health will contribute to health professionals' efforts to effectively work towards improving the profile of contemporary illness* (Milio 1979 p159)

Milio (1979) offered four specific questions on *modern illness* as a basis for curriculum development. By replacing the expression *modern illness* with education these questions would be:

- What is education for health and social care professionals?
- What are the major approaches to deal with education for health and social care professionals' education?
- Why do certain strategies currently dominate?
- How might alternative strategies be developed and implemented?

Tope (1994) concluded that these questions were still pertinent today and that they could equally be applied to education for health professionals. Consistent with Tope (1994) these questions still have relevance when applied to IPE and

form foundations for this inquiry. Tope's (1994) own recommendations for interdisciplinary education at pre-qualifying level included the adoption of Leininger's (1971) framework for interdisciplinary learning at a local level.

More recently Barr (1996) took a critical view of developments in interprofessional programmes and proposed the initial steps towards a typology or classification of reported interprofessional education. Barr proposed that:

> *Interprofessional education is a subset of multiprofessional education, capable to a greater or lesser degree of promoting collaborative practice. While a curriculum for multiprofessional education comprises common content, for interprofessional education it also needs comparative content* (Barr 1996 p341).

Curriculum for IPE should include common, specialist and comparative content with the latter as a bridge between the other two types. Comparative content was defined as opportunities for the professions to learn about one another (Barr 1996). Harden (1998) takes a similar view of interprofessional education but refers to uniprofessional education and transprofessional as extremes of a continuum for multiprofessional education.

There are eleven stages in this continuum which are referred to as isolation, awareness, consultation, nesting, temporal co-ordination, sharing, correlation, complimentary, multiprofessional, interprofessional and transprofessional. As professions move along this continuum, the educational goals, level of contact and curriculum context will alter. Harden's (1998) proposition suggests that the level of interaction between professions varies along the way, and that transprofessional education through workplace learning creates the highest order

of interaction through active learning as opposed to *received learning* when professionals are isolated.

Barr also distinguished between what he termed *received learning* and interactive learning. Received learning relies heavily on lectures and written material and is common in multiprofessional education. Barr (1996) proposed a classification of learning methods commonly used in IPE in the UK. This classification included received learning and five subdivisions of interactive learning. These were:

1) Exchange -based learning, based on psychological theories of stereotypes
2) Observation-based learning, based on psychoanalytical theories and reflective practitioner concept
3) Action–based learning to include problem-based learning and an alternative approach, collaborative inquiry, based on theories of action research
4) Simulation–based learning, based on psychological theories on groups and organisational processes
5) Practice-based learning, based on collaboration

These learning methods were *not mutually exclusive* (Barr 1996 p344). The author acknowledged at the time that these propositions are outcomes dependant as are other variables relevant to IPE such as location, duration, stage, validation, and structure of initiatives. Barr's (1996) conclusion for future research pointed towards quantitative approaches to develop instruments to test hypotheses in conjunction with these variables. He also proposed that:

> *Competency–based learning will have to be embraced if interprofessional education is to secure its place in emerging models of professional and vocational education. Only then will interprofessional education be ready to subject its outcomes to critical reviews in terms not only of collaborative attitudes but also collaborative behaviour* (Barr 1996 p350).

Competency based learning in IPE is not new as a proposition. McGaghie (1978) proposed a core curriculum based on measurable competencies. More recently, Engel (2000) announced the beginning of three major projects to focus on:

1) Generic competencies for change management and adaptation to change.
2) Competencies to facilitate interprofessional collaboration.
3) Recognition and reward methods for creativity and efforts within higher education.

The latter is intended to enable academics to devote more time to these educational challenges.

While many authors focus on models of learning, Olsen (1992) looked at models of teaching as *systems, ecological and cognitive*. The systems model is based on organisational theory to understand and manage change. This model is based on input and output processes. This means that the organisation decides to input change and monitor output by the effects of teaching on learning. The ecological model reflects the environmental issues designed for the teacher to work effectively. The cognitive model reflects the processing of information and how teachers develop and implement schemes to facilitate learning.

According to Joyce & Weil (1996), models of teaching can be categorised into four families based on the types of learning they promote and on their orientation towards people and how they learn. These families are the *information processing, social, personal and behavioural systems.*

It is evident that there are different views to describe frameworks for teaching and learning. If the traditional separatist model for health and social care professions is replaced by IPE, there is a need to examine the frameworks underpinning this form of teaching and learning. Moreover, the role that teachers play is pivotal in assessing, implementing and evaluating initiatives. If the principles of IPE as outlined by CAIPE (1995) are applied, there are resource implications for learning in smaller groups, preparation and support for teachers and for planning and administration of programmes. The intellectual property of professions, the language of professional and non-professional groups, and strategies to facilitate IPE are features that require further investigation.

Dewey (1963) proposed that the principles of continuity of experience and interaction are essential in classifying experience as educational. Interaction assigns equality to both external and internal conditions *'when taken together they form a 'situation'* (Dewey 1963 p42). When the educational experience has positive effect collateral learning should ensue. Hence, enduring attitudes are formulated and the desire for future learning is fostered. These elements can be reinforced when the principles of continuity and interaction intercept and unite.

Within interprofessional education, the mixed group of professionals should own the nature and authority of knowledge. Each individual's contribution will bear unique experience of his or her workplace (Øvretveit et al 1997). The teacher as facilitator needs to be skilled to unravel these experiences with the group through reflective processes. The consequences should, in progressive educational terms, create a 'whole greater than the sum of the parts' as new learning takes shape.

Chapter 3

Policy and Practice of Interprofessional Education

Introduction to Chapter

This chapter gives a review of the policy and practice of IPE. Successive changes in government policies for the National Health Service (NHS) have influenced professional education. The chapter gives an overview of these policies and the consequences for the education of key professionals in interprofessional education.

3.1 NHS Government Policy Influences on IPE

Unlike general education policy, educational policy for health and social care professionals is influenced by and crosses the university sector of higher education, NHS consortia and professional statutory bodies. With such a concoction of influencing forces, it is difficult to determine the roots of policy or by whom the spread of change is most affected. Over the past decades, successive governments have played an increasing role in determining educational policy for health and social care. This chapter shows how government policy for the NHS has resulted in the present policy for health and social care and subsequently influenced the growth of interprofessional educational policy.

The NHS structure is one of the most complex because of its enormity. As an organisation it uses 'marketing' principles yet is non-profit making and ostensibly care is freely available (Boaden 1997). The health and social services sectors

individually provide policy makers with an enormous task, besides their efforts to combine forces through interprofessional work.

Boaden (1997) used the basic system model to examine policy development within the NHS. This analogy suggests that the NHS is a system designed to deliver organised authoritative decision making. A systems approach recognises the interactive processes between the environment, physical, socio-economic and political, and the individuals, groups and organisations involved within it. A loop mechanism allows feedback through democratic processes and influences policy formation and implementation (Boaden 1997). Within this proposed model there are *formal* horizontal and vertical levels of policy formulation and decision making with clear divisions in terms of power, hierarchy and responsibility (Boaden 1997; Colebatch 1998). These dimensions are reliant on each other. A policy may be made through the vertical lines of power in decision-making. Nonetheless, the complex relationships between participants in the horizontal dimension, their level of agreement, disagreement and commitment will influence how policy is decided and ultimately how it is enacted.

The first step is to recognise the range of roles that form an informal web which parallels or intertwines the formal matrix of policy development (Boaden 1997; Colebatch 1998). There are political, professional, managerial and administrative roles involved in policy development for interprofessional education (Boaden 1997). Horizontal integration of policy for IPE means that all the professions should be involved (Owen 1998), while vertical integration means a strand of continuity in IPE should link all of the academic levels.

This approach to educational policy determines input from all interested parties and suggests a *needs-demand* model reflecting the environment. However, as Boaden (1997) indicates, other influences come into play in policy decision making, such as, the government's willingness and ability to give support and resources.

The root of decision making from the professions' stance is *demand,* whereas *resources* are the source for decision making at government level. As government policy filters down through organisations, the structure for decision making is often distinct from the processes around it, resulting in decision making that is dependent on resources and support. Resources allow policy conversion into action, but within an organisation as large and complex as the NHS, resources can never match demand. Thus priorities are usually set.

Conversion of policy is not automatic, instead each facet contributes to the debate about government policy and its conversion into action. Discussion and debate surrounds the ideology of interprofessional education and the political and economical context (Horder 1993; Barr 1992; Webb 1992). The issues regarding such strategies as policy development, funding and delivery of education are as yet ill defined.

Policy can mean different things to different people, but one can agree that there are at least three core elements in how the *term* policy is viewed. These core elements are authority, expertise and order (Colebatch 1998). The policy for IPE within the NHS shows that the *authority* rests with the government who endorse

it. Still international influences will partly direct and or dictate how policy is formulated. Policy for interprofessional education is no exception to international influences. The need for policy on interprofessional education and practice has been driven by the World Health Organisation (WHO 1973) in response to the high cost of health and social care, the uneven quality of systems and the inequality in access to and provision of health care and social care worldwide. The focus on partnerships and alliances to help alleviate these problems has created a forum for professionals to learn and work together.

National policy formulation will generally echo the views of significant players, and accordingly this *expertise* will be reflected in core element of policy formulation (Colebatch 1998). *Order* implies that a common framework underpins the policy decision, which will encompass a range of activities. However, the attributes of authority expertise and order are not so straightforward, especially when an implementation of policy relies on interpretation by various occupations and possible tension between these core elements.

Policy analysis for IPE demands that individual professions partake in reviewing the problem and clarify potential policy directions (Casto & Juliá 1994). In America the Ohio State University responded to the Ohio Commission on Interprofessional Education and Practice and developed a policy analysis Panel to interconnect the needs of clients with interprofessional resources (McCroskey & Einbinder 1998). Part of the role of the Panel was to bring professionals together for analysis of public issues, and train them in developing collaborative strategies for generating and improving policy. This method facilitated professionals in

determining policy of significance to the clients and implementing it accordingly. This type of development is a positive move towards congruency about policy with representation from all interested parties.

In the UK major reformation of health and social care structures and policy within the NHS has traditionally led to disagreement and controversy between politicians, professionals, and public opinion. The following summary of recent reforms will highlight areas of conflict between policy and those enacting or implementing the directives.

Since the inception of the NHS changes in policy were gradual up to the 1970s. Since then successive Governments have shaped the NHS to conform to a contemporary *Review* often within a culture yearning for stability. The first 'major reform era' began in the late 1960s and early 1970s along with the overhaul of central and local government departments (Boaden 1997). These reforms quickly became a watershed, with a Royal Commisson on the NHS in 1979, followed by major policy changes in and throughout the 1980s.

The Conservative government introduced consecutive changes to the structure within little more than a five year span. The Griffiths' Report (DHSS 1983) introduced a change in management through the leadership of general managers. This was a major change in management structure, which broadened decision making to deal with the external pressures facing the NHS through changes in society and health and social care requirements. However, the new management faced internal opposition from professionals. This manifested in 'tribalism', *the*

tendency of professional groups to cherish their historic rights to govern their own affairs (Thompson 1990 p93). In juxtaposition with tribalism was the cliché of a *seamless service* drawn from the 1983 proposals by Sir Roy Griffiths.

A technical management approach was insufficient to achieve a cultural change. The general manager era was propagated by the Government's concern with cost and cost-effectiveness. The Post-Griffiths era developed out of the White Paper: *Working for Patients* (DOH 1989a), which brought about the concept of internal market and the contract nexus (Dickens 1990). As the concept of 'market' cannot exist easily within a non-private organisation, thus a 'quasi-market' was established. Political ambition to highlight managerial control, yet show recognition of patient's rights, led to the *Patient's Charter* (DOH 1995a) referred to by Boaden (1997 p27) as *the quasi-consumerism in a quasi-market.*

This change in policy was reflected in the marginalisation of professionals in policy making, who would hitherto have been consulted (Boaden 1997). Nevertheless, implementation of policy depended on their efforts and support. This divergence ultimately created a chasm between policy and implementation, or at least non-compliance.

The approach to policy making was now adjusted to meet the demands of new market forces introduced by the purchasers and providers competition, therefore service delivery became fragmented to some extent through independent NHS Trusts. There was the conflict of funding through central targets in opposition to the autonomy and decision making of local establishments. Even locally, there

was often fragmentation and independent, often competitive, provision of education and care and overlap of provision (Audit Commission 1992).

Multidisciplinary /multi-agency collaboration became imperative for the effective planning and delivery of services (DOH 1989b). Primary health care has been at the forefront of change in health system reforms in the UK since the 1980s. Several policies developed out of the NHS and Community Care Act (DOH 1990). The structure of contracting services shifted the balance of care from acute hospitals and long stay institutions to the community care and had a major impact on the workload of the Primary Health Care Team. The functions of 'purchaser' and 'provider' of health services were separated and NHS Trusts were developed with the introduction of fundholding in General Practice (DOH 1991).

Government policy had now developed a system of fixed budgets, and independent Trusts within hospital and community services. Prominent in these policies was cost-effectiveness and rationalisation of resources. The workload intensified without additional resources. Hence the plea for partnership, collaboration and working together was reiterated through the 1990s and up to the present day. The government's White Paper *The Health of the Nation* (Secretary of State 1992) and *Targeting Practice: The contribution of nurses, midwives and health visitors* (DOH 1993) also focused on partnerships to provide multidisciplinary solutions supported by multidisciplinary education initiatives.

Fundholding practices were set up but the intentions of decentralisation of power did not manifest within these changes. This wave of change in the 1990s

introduced market mechanisms of a competitive nature through the invention of NHS Trusts and the abolition of Regional Health Authorities, District Health Authorities, and Family Health Services Authorities. Despite the emphasis in the Griffiths Report (DHSS 1983) of the need to involve the health care professions, especially medical professionals in management, this was not done until the clinical directorate model of management evolved. The aims inherent in this type of management model were accountability, decentralisation and clinical efficiency, with a focus on local services.

The next period of change began when The Health Authorities Act (DOH 1995b) introduced health authorities and hospital and community Trusts. Here lay the responsibility for purchasing and providing health and social care within fixed budgets, necessitating rationalising of human resources to withstand the escalating demands for services. One tier practices led by Primary Care Groups (PCGs) began to flourish as a result.

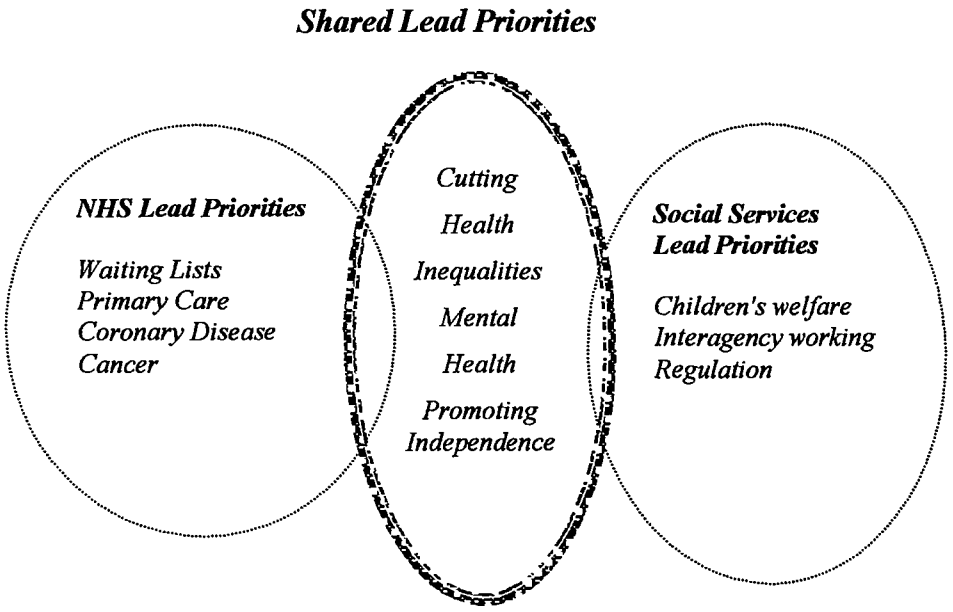
The planning and commissioning of non medical education was devolved to Consortia (NHSE 1997a). The responsibilities of Consortia included assessment of workforce requirements across health and social care and staff development. These accumulative changes brought an increased focus on interprofessional education and interprofessional practice.

3.2 Recent Government Policy Implications

The Modernising Health and Social Services: National Priority Guidelines policy (DOH 1998a) brought in by New Labour has reassigned the structure of policy

and emphasised implementation and monitoring of 'working together ' or joint collaborative work between health and social care sectors. This was the first direct move to integrate services through policy, fiscal and evaluative processes. The government has emphasised the need to breakdown boundaries and has identified shared lead priorities for health and social care. Figure 3.1 shows the individual priorities set for health and social services and those identified as fields for joint work.

Figure: 3.1 Individual and Shared Priorities



Lip service has been paid to integrated services for the benefit of the population for decades. The present reforms state categorically that:

> *Effective joint working that puts people's needs before the convenience of the organisation is a major challenge. There is now an opportunity to energise partnership working; between organisations, with service users*

> *and their carers to reflect better their wishes, with local communities, and with the voluntary sector. Better partnership working needs to go further than improving the interface between health and social care. It should bring together health, social services, and local government more widely, to tackle the health agenda, as well as integrating services* (DOH 1998a p4).

Consequently, breaking down barriers between services and professionals is a priority for health and social services. This policy structure to develop and integrate services, as opposed to the previous structure of internal market forces, has proposed increased power and accountability for Local Authorities. It is proposed that partnership will be promoted through Health Improvement Programmes, Health Action Zones, and Primary Care Groups, which will combine a range of health, social, and local government services working towards common objectives. Crucial to the government changes is the treatment of health and social services as *one* integrated service to tackle inequality, breakdown barriers and improve standards (DOH 1998a).

The Government's aims are to develop a seamless service through sharing of information, information management and dissemination through technological systems in hospital and community settings (DOH 1998b). In addition, this strategy document highlights the need for multiprofessional care pathways.

In opposition to the government's objectives to create a seamless service is the notion that health and social services have distinct functions and professionals are developed to respond to the needs of the public from a particular remit. In general the public demand the 'expert' in whatever social or health deficit reflects their

circumstances. To meet the demands of the public professionals need to function collaboratively and in a fashion that is evident to the client.

Modernising the NHS (DOH 1998a) is also an effort to develop quality responsive services. This appraisal of health and social services introduced a ten-year plan with a vision to design a model around the needs of patients/clients and not the institutions.

Figure: 3.2 Framework for Policy Development

The above Figure shows the new framework for policy development implementation and regulation. This government action clearly emphasises a route whereby policy guidelines are developed through a national centralised agenda (National Institute for Clinical Excellence), with onus on local implementation through Clinical Governance. The Commission for Health Improvement acts as *the watchdog* for implementation and evaluation. A major

force driving policy within the NHS is the push for clinical governance and clinical effectiveness through combined efforts of all agencies within the structure. Education, practice and research respond predictably to compelling government forces. However, responses are never straightforward because of the convoluted mesh that intertwines and disconnects the health and social care systems from themselves and each other.

Figure: 3.3 Quality in the NHS

Partnerships	Policy Development	Process
Government & Clinical Profession	Department of Health, NHS Executive	Setting Quality Standards Fair access National Standards
NHS managers, patient/user representatives,	National Institute for Clinical Excellence (NICE)	Clear authoritative guidelines for frontline staff and patients
National Service Frameworks	National Service Frameworks Varied care areas	Care blueprints to define how services are best provided and to what standard
Health Improvement Programmes led by - Health Authorities, Health Action Zones, Primary Care Groups NHS Trusts, Local Authorities voluntary sector, communities	Process of Implementation Clinical Governance Professional Self-Regulation	Delivering Quality Standards Lifelong Learning Training needs Team working Open and accountable
Commission for Health Improvement National Framework (Assessing Performance)	Monitoring Quality Standards Survey of Patients and Users	A rolling programme of independent assessment/audit of local action Key, valid indicators Annual feedback from patients, service users and carers

The policies for *Quality in the NHS* (DOH 1998c; 1998d) introduced a platform for decision making with complementary new bodies (see Figure 3.3) to develop, deliver and monitor quality. This new framework places partnerships at the core in identifying standards of, and for practice. Performance Improvement will be measured against six dimensions:

1. Health improvement
2. Fair access
3. Effective delivery of appropriate health care

4. Efficiency
5. Patient /user experience
6. Health outcomes of NHS care

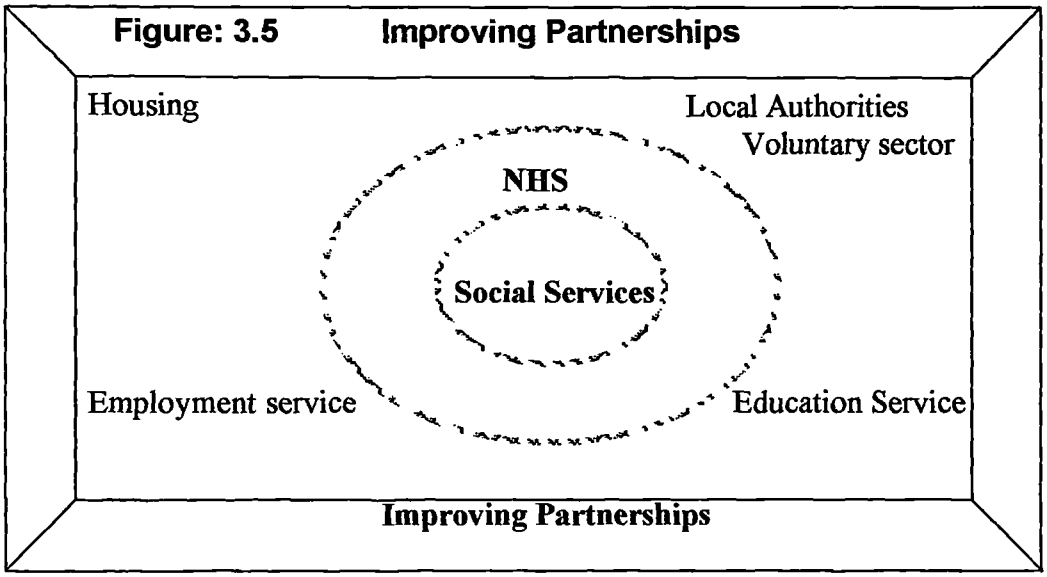
A similar framework for assessing performance of social services has been developed. These performance assessment frameworks will be used as yardsticks to identify and share best practice and award or penalise through the funding mechanisms. The White Paper (DOH 1998e) sets out the changes in structure and delivery of social services, with two out of seven chapters devoted to educational reforms and working partnerships. The following Figure 3.4 outlines the sections affected by change.

Figure: 3.4 Priorities for Services for Adults and Children

Improving Protection	**Proposal**
Eight Regional Commissions for Care Standards -Independent statutory Regulating Bodies	National standards -inspection and regulation -accountable to Secretary of State
Quality projects programme	Improvement in standards for children in care
Improving Standards in the workforce	**Proposal**
General Social Care Council	Statutory Body for social care workers Code of Practice, Fit for Purpose
National Training Organisation	Promote and maintain occupational standards. Training needs analysis
Improving Partnerships	**Proposal**
Social Services	Partnerships NHS and with non-statutory agencies, voluntary and independent sectors in care provision
Improving Delivery and Efficiency	**Performance Framework:**
Government and Local government -Best Value Regime -Performance Assessment Frameworks	-Role clarification and responsibilities for standards and quality -Clear objectives and priorities -Joint working to ensure high standards -New systems for monitoring efficiency of delivery of services

Improving Partnerships (see Figure 3.5) means *flexible partnership working which moves away from the sterile conflicts over boundaries* (DOH 1998a p1). Examples of government initiatives to facilitate joint working are; better service

for vulnerable people, promoting independence, and a long term care Charter, and the development of national frameworks to cover both health and social care.



Frank Dobson, the then Minister for Health, is quoted as saying in the launch of the National Priorities Guidance Policy:

> *We will break down the Berlin Wall between health and social care by meeting these tough modernisation targets. For the first time in the history of the NHS and social services, the Government is moving beyond the stop-go short-term of the annual planning cycle. Now both the NHS and social services have a stable three-year plan. For patients and users this will mean quicker, better-integrated services in communities all over the country* (NHSE 1998a p1).

Moreover, the government has clearly indicated that there is no case for 'job reservation' within social services. Restructuring of social care will *break down traditional roles or functions, which are in any case difficult to define* (NHSE 1998a p5).

The constant evolution of the health and social care structure has profound effects on implementation of policy. Debate surrounds such issues as the nature of the

workforce, conditions for partnership, overcoming barriers to collaboration, and valuing and using the contribution of non professionals such as carers. Furthermore, education needs to remain abreast of these changes. Interprofessional education is recommended as a means towards this end, resulting in discussion and research into the nature, process and outcomes of such nationally and worldwide.

3.3 Implications of Policy for Professions

The pressure to restructure educational policy in general links with globalisation of the economy and the movement towards 'cooperative manageralism' (Taylor et al 1997), which implies a plan based, outcome orientated and management led view to restructuring. These forces created a move from centralisation to decentralisation of policy for market forces (Taylor et al 1997). Moreover, this movement in policy formulation is never static. Other pressures such as conflict of interests of various parties influence implementation of policy.

Policy often espouses equality in education but there is sometimes a dichotomy between rhetoric and reality. Policy frequently demands effectiveness through a process, product and outcomes model while practitioners are faced with conflict in how the process can be applied effectively and efficiently to match the expectations of policy (Øvretveit et al 1997). The demand for integrated services and working in partnership has focused professions on teamwork.

The next section discusses this collaboration through partnerships and teamwork.

3.3.1 Working in Partnership

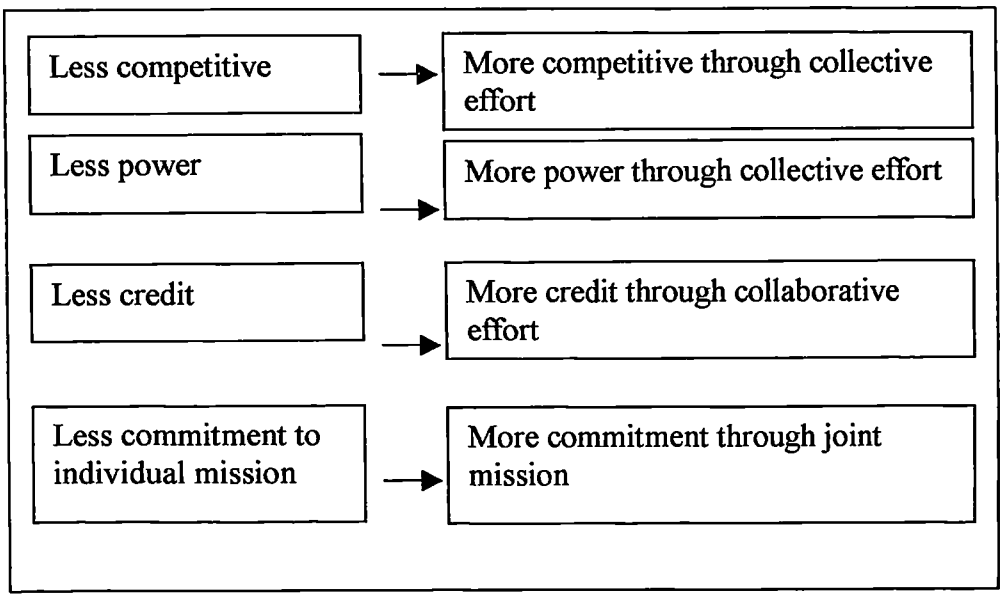
The emphasis on partnerships and integrated services for health and social care pose some of the greatest challenges for interprofessional education. There is a belief that teamwork can lead to synergy through people working interdependently to achieve shared goals and in the process creating a more successful organisation (West & Poulton 1997). Primary health has benefited from teams working towards common or shared goals for some time now (Owens et al 1995). However, with innovation and change in health and social care policy the nature of teamwork has to advance to keep pace with these changes (Pearson & Spencer 1997).

Interprofessional collaboration can refer to *a variety of practices and relationships that form a sort of hinterland of meaning behind policy objectives* (Biggs 1997 p186). Terms such as collaboration, coordination and cooperation are often used interchangeably. Each implies different degrees of closeness and interaction between professions or agencies. Interprofessionalism likewise can be interpreted from different slants that revolve around identity of the mixed groups. This semantic problem means that interprofessional work can fall prey to the influence of different policy and practice environments (Biggs 1997). In addition, for the researcher to decipher the meaning of collaboration in different interprofessional environments locally, nationally and internationally is extremely difficult.

Loxley (1997) developed a conceptual framework for interprofessional collaboration using the theories of social interaction to highlight structures, power

culture and values in relation to collaboration. Accordingly, for professions to collaborate there are certain requirements such as the power to combine and act within a culture conducive to collaboration. This suggests sufficient openness between structures so that trust is sustained over time (Loxley 1997). This framework provides a basis for reflective practice and education.

Figure: 3.6 The Paradox of Collaboration



The paradox of collaboration (Figure 3.6) is that through the process individual professions become less competitive yet competitiveness increases through joining forces. The same effect can occur in relation to power, credit and commitment to a mission statement. Consequently, it is possible to gain stronger power and influence through collaboration by challenging values (Casto 1994). The principles of interprofessional education propose to cultivate collaboration (CAIPE 1999). Casto & Juliá (1994) identify interprofessional care and collaborative practice as requiring several key elements such as a holistic perception of the individual and teamwork to include task and maintenance functions. Professions require a body of knowledge measured and compared with

that of other professions and socialisation to their own and other professions (Loxley 1997).

Collaborative practice espouses increased satisfaction for all participants including clients. The seeds for change require concern for quality of care, cost effectiveness, and job satisfaction within an organisation (Pritchard & Pritchard 1994). Some of the practical difficulties in collaboration are described as irrationality, competition and defensive mechanisms to uphold tradition (Loxley 1997). These obstacles often manifest themselves when the individuals within the organisation are not receptive to change and stereotypical deep rooted attitudes exist.

Individual and or professional resistance to collaboration is frequently reported. Hugman (1995) refers to this as contested territory and boundaries between professions in the context of organisational policies and change. The problem has been described as tribalism by several authors (for example; Vanclay 1997, Andrewes et. al 1997; Weinstein 1993). Tribalism in the workplace has been reported where boundaries between professionals and non-professionals were an additional factor (Andrewes et. al 1997). The recurrent change in how services are structured constitutes a need for re-mapping boundaries and interlocking or overlapping knowledge and skills. The postmodernist concept of *dedifferentiation* often applies in the context of IPE. Thompson (2000) describes dedifferentiation as recognising the arbitrary nature of boundaries between professions. Using this concept, there are dangers in maintaining strict divisions or unduly restrictive boundaries. Several authors claim that the development of teamwork is the source

through which restrictive boundaries can be resolved (Engel 1994; Pritchard & Pritchard 1994).

If the core of interprofessional collaboration is teamwork, the group of participants have shared common goals and agreement on a mutually acceptable plan of action (Engel 1994). Several prerequisites underpin teamwork such as the individual's competence in their own specific profession, mutual trust and equity as team members.

The issues which best describe teamwork of an interprofessional nature are communication, values and norms, roles, leadership, decision making and conflict resolution (Hugman 1991). Hough & Goad (1991) identified some of the key elements in successful interprofessional collaboration. These elements refer to performance in one's own discipline, negotiation and communication across boundaries and decision making and conflict resolution.

A team effort demands a shared sense of purpose among the group members and a level of interaction that would enable them to accomplish more together than each professional group individually could achieve (Casto & Juliá 1994). This means that interprofessional teams differ from other teams because the processes involved:

> *..produce an expanded level of thinking that is not possible in multiprofessional or single-professional teams. The analysis and synthesis of thought that takes place in the interprofessional group is an outcome greater than the sum of the parts that make up the team. This expanded level of thinking is the unique and desired outcome of interprofessional teamwork* (Casto & Julia 1994 p39).

Conversely, Casto & Juliá (1994) conclude that professionals are not trained to work together and the service structures to facilitate interactions are inadequate. Three years later, the same conclusion was drawn that despite the emphasis given to teamwork, healthcare professionals are still trained for independent, autonomous practice (Vanclay 1997). She suggested that learning to work in teams must be part of the education of all professionals, and must be continued after qualification.

Juliá & Thompson (1994a) suggest that interprofessional teams are different from others, as they are primarily task oriented, using problem solving models to deal with the process. External forces already determine the purpose of the team, therefore certain characteristics apply:

1) That boundaries are open to the external environment because external factors sanction and give purpose to the team
2) There is a criterion to judge effectiveness of group functioning.

The criteria includes adherence to the group structure by individuals and the group, the quality of the completed task and reflective appraisal of the maintenance functions of the group (Juliá & Thompson 1994b).

Studies in primary health care have recognised the inhibiting factors to successful teamwork that are intensified by the rapid changes in structure and provision of social and health care services (West & Poulton 1997). Conflict and the resolution of such is part of the task and maintenance functions for teams. Blake

& Mouton (1970) suggested a way of dealing with conflict through a problem solving approach where differences

> *...are subject to resolution through insights that permit protagonists themselves to identify and implement solutions to their differences upon the basis of committed agreement* (Blake & Mouton 1970 p416).

Several authors describe approaches to conflict resolution applied by interprofessional teams such as; avoidance, smoothing it over, exertion of power, forcing solution through domination, compromising, bargaining, withdrawing or confronting.

The team deal with the social, economic and health life (physical, emotional and spiritual) of the client. The decisions are uniform and the client can encounter different members of different professions based on the first point of contact. A multiprofessional perspective may be required for certain health and social concerns of the client (Loxley 1997).

A way of understanding health and social care professionals task functions has been described as problem solving orientation, whereby professionals have a common discipline oriented and systematic way of thinking about a situation when developing a professional plan of action to resolve a problem. This suggests a common basis though the language used to describe the method may vary. The next section discusses task and maintenance functions of teams.

3.3.2 Task and Maintenance Functions

Team collaboration is dependent on task and maintenance functions, which are related and complementary. Effective integration of task and maintenance functions leads to harmony and interactive functioning within a team.

> *Without attention to and effective integration of these essential functions, interprofessional collaboration would not be possible* (Juliá & Thompson 1994b p42)

The functions are composed of several elements. Elements within each function are interrelated and each function is interrelated (Russell & Hymans 1999). Task functions are significant for the problem solving process that groups undergo using reflective intelligence. Thus task functions relate to how the team members' thought processes promote collaborative problem solving. The problem solving process should therefore identify the balance between task and maintenance functions.

The maintenance functions or the interactive processes within a team will depend on the framework of variables used to describe 'teamwork' The maintenance functions have been described as the variables within the team process such as communication, values and norms, leadership, decision-making and conflict resolution (Julia & Thompson 1994b). Consequently, the effectiveness of the group is based on capability to do the work and show ability to manage itself as an interdependent group of people. However, the task of functioning as an interprofessional team may be complicated by the professional heritage of each profession and the varied conceptual frameworks applied to health and social care.

Brown (1988) infers that interdependence is shaped by the task goals of the group. If relationships are positive then cohesion and cooperation are likely to enhance performance. Alternatively, negative interdependence leads to competition. There are instrumental task related group processes, but of equal

importance is the socio-emotional dimension, which express feelings towards others in the group. These aspects can be recognized through careful observation of interaction in groups.

Conventionally the physician has taken the leadership role, however, within interprofessional teams this may not be necessary or desirable. Decision making can be through authority, minority, majority, default, and consensus or consent. Education for interprofessional collaboration requires flexibility of both students and faculty, is a time consuming endeavour, students require preparation on the dynamics of groups and pre-planning by faculty is essential (Russell & Hymans 1999).

Bope & Jost (1994) looked at the factors that affect the form, function and structure of interprofessional team collaboration. Interprofessional collaboration takes many different forms, which will be influenced by financial, location, legal and other constraints. Common forms of collaboration are described as conferring, co-operating, consulting, multiple entry and teamwork. Conferring demands trust to informally share observations. Cooperation is less structured and requires sharing of ideas and knowledge and possible action. Consultation takes place when one professional seeks the advice of another professional's specialised knowledge.

The multiple entry form of collaboration means that different professionals will enter and exit the care scenario at different frequencies and for different time periods. It will demand conferring, cooperating and consulting over time. In

comparison to the latter forms of collaboration, teamwork requires *defined groups of professionals that consult, confer, and cooperate formally and deliberately over a considerable period of time* (Bope & Jost 1994 p62). In reality, the composition and frequency of interprofessional teams will vary considerably (Barr 1998; 2000).

The positive effects of teamwork have been well described. Richardson (1986) succinctly summarises positive outcomes of teamwork as; mutual goal attainment, collaborative, cooperative joint activities, maximum utilisation of knowledge and skills, open exchange of information, opinions, feelings, communication, planning and decision making, reduce pressures and stresses and enhance personal growth. There should be a sense of cohesiveness, security expediency and well planned actions for the benefit of consumers. Just because people work jointly does not mean that teamwork happens.

Other factors affect forms of collaboration such as professional liability, accountability, statutory licensing, scope of practice and clients needs. A generic description of interprofessional teams is not so simple a phenomenon (Knapp & Associates 1998).

3.4 Implications of Policy for Education

This section begins with a discussion on IPE in relation to interprofessional practice. Examples of collaborative projects are identified. These are followed by an overview of policy implication for professional and teacher education.

3.4.1 IPE for Interprofessional Practice

There are some common assumptions about interprofessional practice. One is that this approach produces effective resolution of complex client problems. Two, that effective teams show mutual recognition and appreciation of the role and resources of each participating profession. Three, that the outcomes are beneficial to the client and interprofessional team members (Lee & Williams 1994). In reality, the conditions are far more complex.

Mechanisms to develop collaborative work are identified as exhortation, joint planning and joint funding (Loxley 1997). Collaboration is not an innate characteristic within a system where the balance of power is unequally distributed. Historically relationships between the professions in community care have been hierarchical. Even when the workforce became more autonomous with a mix of health visitors, district nurses and social workers, the care of patients was not co-ordinated as a joint effort. Government support for teamwork and interprofessional collaboration has encouraged a change in attitudes.

The majority, (some 80%) of health care needs in the UK are now met within primary care with a driving force within NHS policy to switch from hospital to community. As primary care increases, the expectations are that specialist roles will expand which could result in fragmentation of care (Vanclay 1997). One option in preserving continuity is through joint work of teams.

The consumers of health care want to receive integrated services, which reflect their needs rather than emphasising professional boundaries (Tope 1999). This

suggests that the inclusion of other agencies such as the voluntary services along with professional groups in shared learning initiatives is essential. Previous involvement of agencies outside the professional arena and/or 'users of services' in developments were more or less a lukewarm effort. Now the prerequisite for change placed the focus on the essence of the health system, that is, the public. The NHS Executive (1996) emphasised the responsibility of health service providers and Health Authorities to inform the public and raise awareness of staff through training and briefing. Correspondingly, several joint training initiatives have been reported.

One collaborative training programme, jointly Commissioned by a Health Authority and Social Services to integrate health and social service teams (Jones 1992). The programme aimed to explore policy change, nurture negotiation skills, investigate and unravel the nomenclature between both sectors and to increase dialogue through shared learning. Results indicate that successful dialogue developed.

Key indicators for joint working in Mental Health have been developed by collaborative efforts of the Social Services Inspectorate and the Sainsbury Centre for Mental Health (Hancock Villeneau & Hill 1997). This 2-year project resulted in the piloting and testing of 6 Key indicators of effective joint working in mental health between health authorities, trusts, and local authority social services departments. Partnership, teamwork, collaboration and sharing of management are transparent and joint training initiatives and networking are explicit in the indicators.

Promoting Action on Clinical Effectiveness (PACE) is an example of a network of health and social care personnel dedicated to researching and disseminating evidence through 'action learning' (Dunning et al 1998). Through PACE, 16 local projects have been selected and research is presently on going. A forum for sharing ideas, progress and problem solving is available through this network. The project shows how health authorities could positively use evidence-based practice in their commissioning role.

Casto (1994) made certain assumptions about interprofessional education for interprofessional practice. He suggests that interprofessional education:

1. Should be provided in areas where professional education programmes have common or overlapping interests.
2. Should be provided in areas where it would be in the client's or society's interest to enhance communication and cooperation between the professions.
3. Should enhance both the student's knowledge of their professional area of competence and their skills and knowledge in interprofessional practice.
4. Is an essential element at all stages in professional education, including lifelong learning programmes.
5. Moves through a progression of awareness.
6. Requires the institutional commitment of funds, personnel, and physical facilities.

In the absence of the above factors interprofessional education has neither 'integrity nor continuity' (Casto 1994 p95).

3.4.2 IPE and Professional Education

There is evidence of IPE policy formulation and implementation even prior to recent guidelines. Collaboration between professional bodies in developing interprofessional initiatives have existed for some time, for example in educational programmes for care of people with learning difficulties (GNC & CCETSW 1982; 1983).

Response to policy can be seen in the increase in educational initiatives of an interprofessional nature between 1986-1994 (Barr & Waterton 1996). This increase rose steadily until 1992 where a more sudden incline is noted. The increase cannot be seen as implementation of government policy only, but inherent in the merger of professional education of nurses, midwives and health visitors into universities.

This merger caused education planners in higher education institutions to take account of similar or core topics for nurses and other health and social care professions. This meant that efficient use of teachers and resources was instigated within a modular framework, while simultaneously meeting the requirements of the NHSE's directives (Miller et. al 1999). Paradoxically, the provision of educational initiatives that state *shared learning* within a common module provided an easy fix solution to political targets for the NHS. Moreover, large multidisciplinary groups were accommodated within the modular structure.

Lessons can be learnt from Linköping University (Areskog 1995a; 1995b), which is renowned for developments in multiprofessional and interprofessional

education. For many years educators have formally integrated shared learning into health and social care education programmes. Common elements of programmes are used to unite students from different professional career pathways at the onset of pre-qualifying education and at recurring stages thereafter.

Based on earlier work in Sweden, a programme to develop teamwork was implemented through problem based education in a multiprofessional context. Learning methods involve small multiprofessional teams within a real world experience of caring for patients and case conferences towards the end of the allocation (Wahlström et al 1997).

Russell & Hymans (1999) investigated task and maintenance functions in IPE for undergraduate nursing and social work students in a practical community project. The problem solving processes used by both groups differed. Nurses were more linear in their approach while social work students used more complex and multiple methods towards solutions. Maintenance functions were examined in relation to the cohesiveness of the student teams. Results indicated that members participated equally within the group. The general lesson learnt from the project was that insufficient time or planning is given to educating students to function within IPE groups.

Interprofessional education through reflection and group interaction could facilitate the development of professionals for integrated care. The process of such interaction would be best facilitated within small groups using active

learning experiences and as recurrent episodes through continuing education (Engel 1994). The concept of 'group learning' as opposed to learning 'group dynamics' might be one way towards interprofessional education impacting practice. Cognitive development could be facilitated through 'learning how to learn together' (Dechant et al 1993). Practically, these processes may be facilitated best in the classroom and integrated with reflection on practice.

Balancing didactic and interactive small group learning helped health care students from varied professional backgrounds examine teamwork and collaboration (Parsell et al 1998). The value of this exercise is evident in the positive evaluations from participants. Nonetheless, lessons are inherent in how the structure of organisations and lack of collaboration between teachers inhibits such innovations.

From 1996 onwards, responsibility for planning and commissioning education and training for health and social care professions was devolved from Regional Health Authorities to Education & Training Consortia. The functions of Consortia include planning an integrated education and development strategy to address local and national priorities and to take cognisance of:

> *Shared learning to support team working across professional and organisational boundaries, preparing the health care workforce to provide a coherent service within a primary care led NHS and across health and social care boundaries* (NHSE 1997a p6).

In October 1997, the NHS Executive issued further guidelines on education and training setting out key priorities for Consortia. This guidance reinforced the need for integrated workforce planning across health and social care boundaries and across professional and vocational boundaries. Consortia were directed not to

generate educational programmes without first identifying the need and ensuring sufficient clinical education and supervision. This direct policy initiative was linked to high costs of education through the purchasing provider's framework.

> *Consortia should, within the contracting and financial management framework, be seeking to achieve greater value for money through the application of downward pressures on high cost education providers. Consortia will need to be able to demonstrate the quality benefits of such high cost contracts* (NHSE 1997b p4).

In addition, sharing of learning was seen as a key to personal and organisational development. Ultimately government policy had forced the NHS planners and providers of services and education to form alliances in producing cost-effective, efficient education, to maintain and retain a competent responsive workforce.

Shared learning and multidisciplinary education are no longer covert within policy guidelines, on the contrary, these have become key issues and core characteristics of curriculum content within government policy guidelines; *to work in multidisciplinary teams even where they cross organisational boundaries* (NHSE 1997b p7).

Nurse, midwifery and health visitor education has taken a lead in developing and implementing policies for shared learning and interprofessional education. The UKCC (1992) issued a policy position for shared learning supporting scope for collaboration between professions. The UKCC established a Commission for Education (UKCC 1999) to propose the way forward for nursing and midwifery education at pre-registration level. Their brief focused on 'fitness to practice' to encompass health care trends, standards of teaching and learning, and the position of interprofessional approaches. Linked to the remit for interprofessional

education were issues such as a competency framework using vocational or occupational standards, methods of assessment, teacher preparation, along with the integration of pre-registration education into higher education. This in itself gives a picture of interprofessional education as a route to combine professional education for health and social care and create a workforce with generic and transferable skills.

The profession has consistently argued for academic status with other health and social care professionals. The National Committee of Inquiry into Higher Education (1997) assumed that nurse education would move towards graduate preparation and the RCN (1997) are committed to this. Despite this support and evidence that qualified nurses and midwives are progressively attaining graduate status and beyond, the Commission (UKCC 1999) reneged on recommending graduate status at pre-qualifying level The consequences for interprofessional education are obvious as nursing still holds an unequal stance in the presence of other health and social care professionals in a learning milieu.

The Commission recommended interprofessional learning as a feature of pre-registration education stating that:

> *Appropriate professionals should be targeted, there should be an emphasis upon the equal value of all participants and the content should be carefully chosen and either discipline of service focused. Well planned, shared learning opportunities can provide the means to promote interprofessional understanding, cooperation and communication* (UKCC 1999 p51).

Ethics and communication skills are subjects with scope for shared learning with a proviso that more evidence is required to identify other common skills and

knowledge (UKCC 1999). In contrast, Miller et al (1999) stated that there is value-added learning when the initiative focuses on *shared* rather than *common* learning and propose experiences to build on the following elements; prerequisites for teamwork, client focused, interactive, scenario-based, build a student development model and experiences should be on-going. Tope (1999) suggests that non-clinical modules should be extended to students from occupations other than health and social care.

Social Worker education has undergone a major review in the government reforms (DOH 1998a). National Training Organisation *(NTO)* for Social Services has been directed by government to produce a strategy for education of social workers. Mechanisms to set and enforce standards of practice and professional conduct have until now been absent for social workers and social care workers. Moreover, 80% of a workforce of one million approximately, has no recognised qualifications even though these workers deal with clients (CSWE 1998).

One of the key functions of the General Social Care Council (GSCC), which is formed to replace CCETSW, is to raise the standards of social care staff and ensure that education is improved. Alongside the development and promotion of training at all levels will be the responsibility of the licensed Training Organisation for Personal Social Services referred to as the National Training Organisation (NTO). This body resembles other employment-led organisations. It will represent the whole sector and service users. The main functions of this body are to:

- Maintain occupational standards
- Implement workforce analysis

- Identify training needs
- Ensure training needs are met

Examples of social workers sharing learning with other health and social care personnel are not uncommon (Weinstein 1993).

Medical education has not escaped the recurrent changes which will influence how medicine is practised and managed in the future (Engel 2000). Medical education is a complex combination of teaching and learning activities within a professional environment where unplanned learning is an important part of clinical learning (Wilkes & Bligh 1999). This has additional implications in the context of interprofessional education where key characteristics are learnt only through interactive processes. The literature on medical education is focused more on multiprofessional than interprofessional education, with emphasis on competency-based approaches increasing (Engel 2000).

A report of conference proceedings in London (Strunin et al 1998) examined the effectiveness of different models of continuing medical education (CME). Conclusions were drawn that CME is not about how to learn but about managing the learning process. CME must be self-assessed and self-managed. Professional bodies should develop standards for the management of CME (Strunin et al 1998). Wilkes & Bligh (1999) describe establishing and maintaining high standards of teaching and learning in medical education as, *curriculum governance*. Like clinical governance evaluation is a core principle. However, the evidence shows that insufficient effort is placed on assessment and evaluation in medical education internationally (Wilkes & Bligh 1999).

Pharmaceutical education has changed to include clinical experiences to give insight into diseases and help develop communication skills. This means that the student is increasingly involved in patient care (Greene et al 1996). Joint teaching efforts between pharmacists and medics at King's College London show how sessions can facilitate interprofessional learning jointly with meaningful learning experiences for individual professionals. There was considerable co-operation between disciplines and little *nascent professional rivalry* (Greene et al 1996).

3.4.3 IPE and Teacher Education

It is evident from government policy that teachers are faced with the challenge of interprofessional education for health and social care professionals.

Initial Teacher education and training has generally stood separate from any preparation of teachers for professional education. Casey (1997) reported that over half of the academic staff in universities in the UK had received some training in teaching methods. Two thirds of those with any training had done so at the onset of their career. Now that interprofessional educational programmes are relatively common in higher education establishments teachers must be competent to teach interprofessional groups.

Traditionally teachers of nurses, midwives and health visitors are required to undergo formal teacher preparation. The UKCC (1986; 1999) revised the educational standards for teacher education. Now specific standards for the preparation of teachers of nursing and midwifery have been developed (UKCC 2000) that validate a practice oriented approach to teaching and learning and meet

the requirements for membership of the Institute for Teaching and Learning (ITL 1999). The recommendations require teachers to spend a minimum of 20% of their time in clinical placements once qualified. This proposal has been difficult to achieve (RCN 1997). In defence of practice-based education, there is evidence of the failure of the P2000 programme of pre-registration education for nurses, health visitors and midwives, to sufficiently skill nurses (in particular) for their role (Luker et al 1995). This supports the need for teachers to become practice focused.

Teacher education for health and social care professionals is drawn between the different government bodies linked with funding issues. There is no doubt that they are faced with the challenge of interprofessional education. Much of the literature on multiprofessional and interprofessional education refers to collaboration and teamwork in the context of health and social care professions in some capacity or other.

There is a significant lack of literature on how teachers should collaborate and teach within the context of IPE. Moreover, preparation of professionals to teach in interprofessional learning milieu is less evident. Mostert (1998) highlights the gap in teacher education in America in dealing with interprofessional collaboration and professional teamwork in education. The research discussed in the following chapters addresses the teachers' opinions on IPE and their role in developments in the UK.

Chapter 4

Research Design and Methodology

Introduction to Chapter

This chapter gives an overview of the research design and methodology. An illuminative evaluation formed the framework for the research as this allowed a mulitmethod approach to data collection and analysis. The study was a developmental process. It took the form of three surveys. The first survey focused on evaluating the extent and type of preparation of nurse, midwifery and health visitor teachers' for their role in shared learning environments. The second survey investigated nurse, midwifery and health visitor teachers' preparation for, and perceptions of shared learning within the context of their own preparation and work environment. The third survey included teachers in health and social care from throughout the UK. Their views and evaluation of interprofessional education and shared learning milieu were identified from a multiprofessional stance.

The data for surveys one and two was collected between 1994-1995. This data was used to report to the ENB and was published accordingly (Mhaolrúnaigh et al 1995). The third survey was linked to the first two through the type of questions posed to a wider audience using refined methods for data collection. This data was collected between 1996-1997. These surveys provided data for comparison of quantitative findings through statistical analysis. The findings from qualitative data were scrutinised for disparity and similarity within a

uniprofessional perspective and a multiprofessional viewpoint. ACCESS software was used to develop a personalised database for analysis.

This chapter gives the aims of the study and discusses the research methods used to investigate IPE. The discussion includes an overview of evaluation as a research method and the design used in this research. It includes an overview of the methods used for data collection, validity and reliability of the study and piloting of the tools for measurement. The chapter concludes with the specific details pertaining to each survey, and the methods used for data analysis.

4.1 Aims of the Study

The overall aims of the study were to:

1. Identify the extent of interprofessional education and shared learning in ENB approved programmes for teacher preparation.

2. Examine the content and context of these programmes in relation to interprofessional education and shared learning.

3. Investigate the practice and effects of interprofessional education and shared learning in contrast to the separate approaches, from the perceptions of student teachers, newly qualified teachers, experienced teachers, teaching staff involved in the teacher preparation programmes and education managers within nurse, midwifery and health visitor education.

4. Investigate how the teachers of health and social care professionals viewed, experienced and evaluated interprofessional education and shared learning.

4.2 Choosing a Design for the Research

At the onset of this study, there were various reported research methods, which had been applied to IPE and shared learning milieu. These methods included action research, evaluations, surveys, case studies and experimental and quasi-

experimental methods. Most of the studies focused on educational initiatives of varied duration or at different academic levels (Leathard 1992). Some reported studies were specific to a specialist area, for example, learning disability (Mathias & Thompson 1992). Others referred to multidisciplinary practice or collaborative work (West & Pillinger 1996; West & Slater 1996). Thurgood (1992a) surveyed health care professionals' attitudes towards multidisciplinary learning and included a number of teachers in the sample. Others also included teachers in their sample, for example, Munn and Morrison (1984), Freeman (1991), Weinstein (1993) and Vanclay (1996). Buttigieg (1990) examined the requirements for teacher preparation and career pathways for nurses, midwives and health visitors from a unidisciplinary perspective.

The major contributions to teachers' perceptions from a UK perspective have been Jones (1986), Jones (1992) and Tope (1994). Ostensibly, interdisciplinary learning or shared learning was used to signify learning together to work together. The conclusion drawn from the literature was that the small sample of teachers included in the earlier study (Jones 1986) resisted shared educational developments, whereas a different larger sample later on showed positive attitudes to shared learning milieu for interdisciplinary education (Tope 1994). However, none of these studies were designed to examine teacher's perceptions alone.

The research design for the present study adopted the principles of the illuminative evaluation tradition (Parlett & Hamilton 1972) to take account of the wider context of IPE and shared learning in teacher education and IPE

programmes. This type of evaluation is primarily concerned with description and interpretation rather than measurement and prediction. Consequently, it offers an overview of the wider context within a learning milieu. The assumption was taken that the learning milieu was the:

> *Social psychological and material environment in which students and teachers work together* (Parlett & Dearden 1977 p14).

In assuming this definition, it was anticipated that the data would reveal a chain of relationships involving social, cultural, psychological and institutional variables. Different techniques were used to interpret a plethora of questions from various perspectives (Parlett & Hamilton 1972). Accordingly, it was possible to use a triangulation approach to data analysis for the three surveys (Denzin 1970).

4.2.1 Evaluation of IPE

Barr et al (1999) have initiated systematic reviews of evaluations of interprofessional education. The researchers used the Effective Practice and Organisation of Care (EPOC) criteria. This is a derivative of the Cochrane Review system. The difference is that the EPOC deals with topics outside of the strict biomedical arena and includes evaluations of professional interventions such as education, and organisational interventions aimed to impact on client care. The systematic review group examined publications in relation to set criteria. The initial review involved quantitative methods applied to IPE evaluations. The researchers concluded that only nineteen evaluations met the criteria. The results of a parallel systematic review of qualitative evaluations resulted in seventy- three selected studies. This review is still on going.

The conclusions so far indicate that there is a need to widen the methodologies applied to evaluation of IPE. In addition, the researchers suggest that there is a need to strike a balance between evaluation of process and outcomes of IPE. The results established that reporting of research methods applied to IPE is less than adequate (Barr et al 1999). Moreover, they concluded that:

> *Educational evaluation can be seen as a political act. In health and social care a number of bodies, e.g., purchasers, professional and awarding bodies, each with their own (competing) agendas, participate in monitoring the work of educational providers. However, it could be argued that most of this monitoring is concerned with learner achievement for an award as opposed to changes in their practice behaviour and its subsequent impact on client care* (Barr et al 1999 p32).

4.2.2 Evaluation as a Research Method

This section discusses evaluation as a research method and concludes with the reasons for choosing multiple methods to evaluate IPE.

Educational research has had its share of criticism and challenges. One concern is often that educational research does not possess a distinctive disciplinary knowledge base, or its own language, exclusive theories or separate methodologies unlike other disciplines (Mortimore 2000). This is equally true in researching any profession with an emerging body of knowledge for example some professions allied to medicine. Mortimore (2000) whilst valuing this heterogeneity as a benefit sees it as a challenge to create a common frame of reference. The major tasks of educational research in Mortimore's (2000) discussion can be summarised as:

1. To conceptualise, observe and systematically record events and processes to do with learning

2. Analyse such observations, to describe accurately their conditions, contexts and implications
3. Publish accounts drawing on existing theory or emerging theory that will in turn be influenced by the work
4. Further educational improvement

The same conditions could be applied to evaluation as a research method and in particular to evaluation in educational research. Evaluation methodology has several on going debates surrounding such issues as classifications of evaluations (Rossi & Freeman 1993), paradigm stance (Patton 1990) and the purpose and use of different evaluative methods (House 1978). Hamilton et al (1977) provide a historical view of evaluation as a research method. More recently, Rossi & Freeman (1993) have suggested that evaluations differ according to the type of questions asked, whether it is a new or established programme, and the decision making process the evaluation intends to inform.

Evaluation designs tend to take the form of models that reflect a particular method or an approach to a specific evaluation problem (Hopkins 1989). House's (1978) taxonomy includes eight models; systems analysis, behavioural objectives, decision making, goal free, art criticism, accreditation, adversary and transaction. Hamilton et al's (1977) six overlapping models gave an overview of evaluation in Britain at that time. These were:

1. The classical (agricultural-botany) research model
2. Research and development (industrial) model
3. Illuminative (anthropological) model
4. Briefing decision makers model
5. Teacher as researcher (professional) model
6. Case study (portrayal) model

Since then several other classifications have developed which reflect evaluation within different philosophical paradigms ranging from experimental, judgemental, pragmatic, responsive constructivist, pluralist to realistic (Redfern 1998). Some of these approaches reflect concerns such as the stance or position taken by the evaluator.

> *We should not elevate the importance of models unduly*...there is *a need to integrate evaluation and development and to empower evaluators through the acquisition of skills rather than inducting them to models* (Hopkins 1989 p.28).

In utilisation focused evaluation, Patton (1997) takes the premise that evaluations should be judged by their actual use. Patton argues for an evaluation facilitator to work with intended users.

> *Utilisation focused evaluation does not advocate any particular evaluation content, model, method, theory, or even use. Rather, it is a process for helping primary intended users select the most appropriate content, model, methods, theory and uses for their particular situation* (Patton 1997 p22).

Hopkins (1989) concluded that by distinguishing between evaluation *of, for, and as,* it is possible to stress the fact that different *purposes* dictate different *methodologies* and therefore have different outcomes. Patton (1990) examined qualitative evaluation and research methods appropriate to different purposes of evaluation such as *process* evaluation where the focus is on *how* something happens rather than the outcomes or results.

Quantitative approaches can produce uniformity of measures in comparisons across programmes but qualitative measures can illustrate differences and uniqueness between programmes. When national programmes are implemented

locally, there are often variations in implementation and outcomes that cannot be captured or measured with standardised scales. This requires a focus on diversity (Patton 1990).

Patton (1997) claims that with accumulative evidence of exemplary quantitative and qualitative approaches to evaluation, the focus of debate has shifted from rigid adherence to either a paradigm of quantitative/positivist versus qualitative /naturalistic to methodological appropriateness.

Multimethods, or integration of both quantitative and qualitative methods, have gained respect in the wider research world (Creswell 1994) and objectivity and subjectivity are sometimes replaced by fairness and balance (Patton 1997). Whichever paradigm the researcher chooses, according to Patton (1997) there are three primary uses for evaluation which are described as to judge merit or worth, improve programmes or generate knowledge. This suggests that strength of research is not judged by adherence to a particular paradigm only, it is also determined by the adequacy and accuracy of whatever method or methods are applied within the context of purpose, time, and resources (Patton 1997).

The literature review used to inform this study highlighted the dearth of evidence in relation to teaching IPE and a lack of continuity in terminology applied to the concept of IPE. The use of multimethods to evaluate a development where there is still modest evidence seems appropriate. The researcher has to become selective and clearly focused in information management and distinctly, define terminology in reporting findings.

4.3 Design of The Study

The scarcity of research on the role of the teacher in IPE and shared learning environments suggested the need for an overview of the approaches taken using a theory generating strategy to design and methods. The illuminative evaluation method was applied to the overall design of the study. This allowed a multimethod approach to data collection, analysis and conclusions.

The focus was on how IPE and shared learning functioned as influences upon the learning milieu and how the people involved in the scheme viewed the advantages and disadvantages. The research approach also aimed to discover what it is like to participate within a scheme as a teacher, and to discern and discuss the most significant features, recurring commitments and critical processes of an innovation within a such a climate (Hamilton et al 1977).

The research design allowed the researcher to pursue three characteristic stages that aimed to firstly, explore the concept, collect broad speculative data and become informed about IPE. Secondly, select questions from the data for more sustained enquiry and develop a framework for the focus of inquiry in the next stage of the study. Thirdly, the researcher needed to identify general patterns and interpret them within the broader explanatory context.

The orientation phase involved a full literature review and a series of informal interviews with key personnel and other researchers involved directly with IPE. Several discussions took place with members and staff of the Centre for the Advancement of Interprofessional Education (CAIPE) and personnel involved in

the European Multiprofessional Education (EMPE) organisation. The exploratory stage of the study was a focal point in developing ideas and instruments for data collection. From previous research, student teachers' and course leaders' accounts, the concepts that made up attributes of shared learning were identified through Likert scales. The investigative stage involved data collection, analysis and conclusion of findings in relation to the nature of IPE.

4.3.1 Overview of Methods of Data Collection

Quantitative and qualitative data was collected through documentary evidence, structured questionnaires, recorded interviews and recorded telephone interviews using semi structured schedules. Figure 4.1 shows the stages of data collection, the sample targeted, the actual number of participants who responded and the methods used to collect the data.

Questionnaires

Questionnaires were used for the purpose of gathering quantitative data on the teacher preparation courses and to identify the experiences and perceptions of new teachers to IPE programmes. This choice of research tool is widely accepted as valuable in gathering a wide range of data in a short space of time. In addition, ease of access to a larger sample group, speed of response and ease of analysis are recognised benefits of this technique (Oppenheim 1992).

The design of the questionnaires was influenced by the findings from the literature review and the discussions in the orientation phase of the research.

Figure: 4.1 Flow chart to illustrate stages of data collection

Stage of Study		Data Collection	Number of Participants (n)*
Familiarisation Phase		Literature review, Consultation with key personnel Informal discussion with course teachers and students Developing and piloting instruments	Various
		↓	
Survey One 1994	→	Questionnaire (1) circulated (n=17) to Course Leaders at all ENB Approved teacher preparation centres.	n=12
		↓	
	→	Interviews In-depth interviews with Course Leaders in selected centres	n = 5
		↓	
Survey Two 1994-1995	→	Questionnaire (2) circulated to students (143) who had completed teacher preparation programmes in selected centres	n =58
		↓	
	→	Interviews Telephone interview with newly qualified teachers from the 5 case study centres	n = 17
		↓	
	→	Interviews Telephone interview with mentors (n=8) and managers (n=4) in colleges of nursing and midwifery	n=12
		↓	
Study Three 1996-1997	→	Questionnaire (3) circulated to teachers (n=825) of health & social care professionals	n=246

*This column denotes the actual number of participants in the study

Interviews

Discovering the views of participants is crucial to assessing the impact of an innovation in illuminative work. Hamilton et al (1977) note the difficulty of interviewing every participant and stress the need to ensure that appropriate

information is sought from informants or particular groups who have a particular insight into the area of study.

The method of conducting the interviews was considered carefully. Initially, tape recorded interviews were held with participants. As the project progressed it was decided to use the telephone interview as a geographically convenient means of gathering data (Field & Morse 1985). The advantages of telephone interviews include quick response to questions, low refusal rates and the possibility of reaching a large geographic sample (Cassiani et al 1992). Another cited advantage of telephone interview is the reduction of bias because close contact is not possible (Hash et al 1985).

4.3.2 Validity and Reliability

One of the criticisms of illuminative evaluation is the possibility of subjectivity and a lack of reliability and validity of the findings (Hopkins 1989). The research design reflected an inductive approach in which the development of each stage was driven by the findings from the previous stage for the purpose of crosschecking and more in-depth exploration. In so doing any initial subjective perception was teased out and this gave a degree of validity (Hopkins 1989). Construct validity was determined by establishing a chain of evidence, using multiple sources of evidence, refining terminology through the developmental stages, using key informants to review drafts.

The multimethod approach to data collection and the use of triangulation made it possible to compare and contrast data from the same and different sources. This

added reliability and construct validity to the findings (Cohen & Manion 1994; Kimchi et al 1991).

Efforts were made to review the content of taped interviews through transcribing the data and following a path of analysis. The coding of variables and a purpose built ACCESS computer programme database helped to confirm the findings of qualitative data. The computer-assisted analysis is discussed in more detail in section 4.8.1.

The collection of data at different stages helped in seeking alternative explanations and examining internal validity. The inclusion of many institutions was meant to increase the external validity of the study through cross-site analysis. However, within a national context a major weakness lies in the practicalities of comparing different learning milieu within the wider geographical span while accounting for the various models of IPE that may be in operation.

4.4 Selecting and Piloting the Research Measurement Instruments

The data collected in the initial orientation phase facilitated the design of the research instruments used in the first stage of the study and informed the subsequent development of the methodology. A centre that had delivered teacher education within a multi-professional culture for many years was chosen for the pilot work. Teachers and the course leader acted as reviewers and advisers for measurement instruments for survey one. A student teacher focus group (*n=18*) helped to identify possible themes for interviews and assisted in critically

reviewing the measurement tools for survey two. Piloting of the questionnaire for survey three was undertaken in relation to the outcomes of previous data collection and alterations were made accordingly.

4.5 Survey One

ENB approved Teacher Preparation Centres

This survey aimed to

> *Identify the extent of interprofessional education and shared learning in ENB approved programmes for teacher preparation.*

Data collection involved two developmental stages. Stage one was a survey of all the centres preparing teachers in nursing, midwifery and health visiting in England. Questionnaires (Appendix 1) were sent to 17 teacher preparation centres and 12 were returned. The intentions were to use the findings from the questionnaires to identify two centres that had a *high orientation* to shared learning and two that had a *low orientation* to shared learning for the purpose of comparison. However, the patterns in responses to the questionnaire of the study meant that it was not possible to discriminate. In this event the level of homogeneity in the groups was such that it was decided that **five** centres would be used as case studies for the next stage of the research as a more focused approach was required to achieve the next aim which was to:

> *Examine the content and context of these educational programmes of preparation of teachers in relation to interprofessional education and shared learning.*

This stage involved in-depth interviews (Appendix 2) with the course leaders of five centres for teacher education. The purpose of these interviews was to explore

issues that had been raised in the analysis of the questionnaires in the previous stage and to inquire further into the process involved in shared learning in the teacher preparation centres. Interviews were taped to ease interaction between researcher and interviewee and to accommodate analysis later on.

Data analysis of survey one involved descriptive statistics and where possible inferential nonparametric statistical analysis of quantitative data. The database used for the analysis was SPSS. The content of interview data was analysed, transcribed, coded and categorised in accordance with the principles of qualitative analysis in which emergent themes were identified (Miles & Huberman 1994; Beck 1994; Field & Morse 1985).

4.6 Survey Two

New Teachers

This survey aimed to:

> *Investigate the practice and effects of interprofessional education and shared learning in contrast to the separate approaches, from the perceptions of student teachers, newly qualified teachers, experienced teachers, teaching staff involved in the teacher preparation programmes and education managers within nurse, midwifery and health visitor education.*

This survey involved a second questionnaire (Appendix 3). This was derived from the survey of course leaders and distributed to teachers who had recently completed the teacher's preparation courses in the five case study centres. The purpose of this was twofold. Firstly, to explore the new teachers views of their experience of shared learning in their teacher preparation programmes. Secondly, to explore their views on, and extent to which, they were able to apply the

principles of shared learning in their present role as teachers of nursing, midwifery and health visiting.

Questionnaires were sent to 143 newly qualified nurse teachers. The questionnaires were circulated through the course leaders for distribution to the student cohorts in each centre. The number of questionnaires circulated to each centre reflected the attendance records at the time of the study (8, 20, 25, 40 and 50 questionnaires respectively). Questionnaires were sent to the total cohort in four centres. One centre had fifty questionnaires distributed to represent 10% of total cohort of 500 students. In total, sixty (42%) questionnaires were returned and two were omitted from the analysis due to incomplete data. Consequently, the analysis of the questionnaire reflects 58 completed questionnaires (40%).

The largest number of non returns were from the centre with the greatest cohort. It was noted that a large number of the student teacher group at this centre were non-health professionals who may account for the low level of return. The sample was obtained through contact with the course leaders at each site, therefore the researcher was not privy to the participants' personal details or able to send reminder letters.

The next stage involved telephone interviews using a semi- structured interview schedule (see Appendix 4) with 17 new teachers who had completed questionnaires and were willing to be interviewed. The new teachers were asked to indicate if they wished to be contacted for interview. Subsequently this was

followed by personal contact to arrange a mutually convenient time at which to conduct the telephone interview.

Finally, established teachers working as mentors (n=8) to the new teacher group and managers within the colleges (n=4) participated in telephone interviews. These were qualified for a number of years and working as either mentors to the newly qualified teachers or educational managers within the colleges in which the newly qualified teachers were employed. Snowball sampling was used to identify if they were willing to be interviewed and to suggest appropriate times to suit their schedule (Appendix 5).

4.7 Survey Three

Health and Social Care Teachers in Interprofessional Education

This survey aimed to:

> *Investigate how the teachers of health and social care professionals viewed, experienced and evaluated interprofessional education and shared learning.*

This survey aimed to determine how teachers interpreted interprofessional education and shared learning initiatives at post- qualifying level within specified IPE programmes. CAIPE had commissioned a national survey to identify and classify IPE programmes and the results were entered into a CAIPE database that can be revised and augmented regularly (Barr & Waterton 1996). Access to the database was obtained through the Director of CAIPE.

This national survey identified 455 interprofessional initiatives in the United Kingdom (UK). Two hundred of the initiatives were of more than two days

duration. Each entry held a record of the name of the initiating organisation(s) the region in which the initiative was held, the academic level, the title, the length, the year first held, the mix of professions amongst participants, and the name and address of a contact person.

The database was used to select a sample of interprofessional initiatives at post-qualifying level. The criteria for selection were based on:

- post-qualifying level
- length of the initiative (5 days minimum)
- inclusion of two or more health/social care professional groups within the learning environment.

The sample produced 119 (26% of total sample) interprofessional initiatives. This sample was examined in relation to the number of different health professionals who were included in the same learning environments. The nursing Register is categorised in relation to additional qualifications such as health visiting and midwifery. Because of the uniqueness of midwifery in relation to nursing, it was decided that midwives should be classified as a separate profession.

Table 4.1 shows how categorises were formed to identify the number of initiatives and number of professions within these initiatives.

Table 4.1 Categorisation of Interprofessional Initiatives

Category	Number of professions	Number of Initiatives
1	1	9
2	2	25
3	3	25
4	4	22
5	5	15
6	6	10
7	7	10
8	8	1
9	9	1
10	11	1
Total		**119**

The highest number of initiatives resulted in nine programmes that had only one professional group involved and was classified as category one. Analysis of this sample identified that these cohorts consisted of nurses from all branches of the profession and included health visitors in all but one of the programmes.

The breakdown of category two identified 25 courses with two professional groups of which 16 were nurses and social workers learning together. In addition, one of the programmes included nurses and all other professionals allied to medicine without specification. In category three, 12 of the total number of courses included social workers, nurses and one other professional group. From category four onwards, the sample contained varied combinations of health professionals, voluntary workers customers of health care and carers. Within four

categories respectively, there was one instance where more than and/or all professionals allied to medicine could be included. However, the actual professions were not specified. Based on this assessment of the sample, it was appropriate to target all categories including one that included only nurses, with the proviso that the programmes could accommodate interprofessional groups.

The programmes within the sample consisted of 23 at master level, 11 at degree level and 19 carrying the title of diploma. The remaining sample did not specify level according to title. The time span varied from just within the criteria of five days to three years. The most frequent time span of interprofessional educational initiatives was 6-21 days. The introduction of modularisation and variations in the length of semesters within higher education made it difficult to do comparisons between initiatives. The same institution was responsible for delivering more than one of the courses, which meant that 73 distinct institutions were recorded in the sample.

The database gave a contact name for each initiative, however, 20 people were named for more than one initiative. This resulted in a baseline sample of 99 key personnel as contacts. Letters were posted to these key personnel informing them of the research, including the definitions used, and requesting permission to distribute questionnaires (Appendix 6) to teachers at the institutions. These key personnel were asked to either assist with distribution of the questionnaires or alternatively, to suggest the names of the teachers who were involved in interprofessional education. A guarantee of confidentiality in dealing with all information was given at this stage. The co-ordinators were asked to express their

willingness/unwillingness to give permission and assistance with distribution of questionnaires and a stamped addressed envelope was included. Consequently, if permission was required from any other source this was identified and followed up.

A response was received from all 99 personnel either in written form or by telephone contact. Eighteen key personnel stated they were unwilling or unable to give permission to access teachers or distribute questionnaires. Their reason were as follows; three stated that the programmes were not running, ten gave their rationale for not including their programme(s) as either, a mismatch to the set criteria or that access was not viable due to mergers and /or changes occurring within their establishment. Two were unwilling to participate without stating a reason. However, this group offered six other contact names.

The study included 117 initiatives that matched the criteria for selection from the database. Questionnaires (825) were distributed to 86 key personnel for completion and/or distribution. Returns were received from 302 (37%). From this number 56 (18%) were not completed, resulting in 246 responses included in the study.

4.8 Data Analysis

Data collected in the course of this study was analysed using both quantitative and qualitative techniques. Figure 4.2 shows the overall data collection and analysis strategy.

Figure: 4.2 Methods of Data Collection and Analysis

Stages of Study	Data collection	Number of Participants	Data Analysis
Survey One	Questionnaire (1)	12	Descriptive non-parametric statistics
	Interviews Course Leaders	5	Content analysis
Survey Two	Questionnaire (2)	58	Descriptive non-parametric statistics
	Interviews new teachers	17	Content analysis
	Interviews mentors	8	Content analysis
	Interviews managers	4	Content analysis
Survey Three	Questionnaire (3) Teachers to IPE programmes	246	Descriptive non-parametric statistics Content analysis

4.8.1 Computer Assisted Analysis

At the early stages of analysis, the researcher experimented with different statistical computer databases such as EPI and Paradox for Windows. Problems were encountered with the compatibility of software and transferability of files. The SPSS database was selected for quantitative data for survey one and two and this qualitative data was analysed independent of computer software. A large sample was anticipated for inclusion in survey three, consequently it was anticipated that the qualitative data would be harder to manage.

The ACCESS database was chosen to overcome this problem. The development of a custom tailored database took several steps. One of the fundamental steps was determining and developing tables to avoid duplication so that updating would occur in one place only. Each table had to include a set of fields to identify each record uniquely. The next stage was to develop relationships between the

tables and test the design with sample data. Following refinement it was possible to enter the data. The database was structured in two levels as follows:

Level One: Organisation Contact Questionnaire ID.

Level Two: Questionnaire Type

This means that level one information can be used to input other data at any time at level two. The advantages of the custom built database were:

1. Data could be linked to give individual or grouped data
2. New data entries are automatically linked to the completed analysis
3. Qualitative data could be clustered to relate to research questions
4. The database can be used for future data collection
5. Data could be linked between ACCESS and EXCEL databases to formulate statistical analysis.
6. Visual display of all data types can be accomplished through both databases using forms and reports.

At the onset of this thesis, the SPSS was the only database available to the researcher to undertake quantitative analysis. The researcher found that the formation of visual displays and importing of such was cumbersome and in particular, when data was entered it remained static and updating or linking of further data for analysis was not simple. To overcome this problem the EXCEL database was used for quantitative data analysis in survey three.

4.8.2 Quantitative Data Analysis

The quantitative components of the questionnaire were subject to a range of descriptive and non parametric statistical tests. The first step in organising the data was to readdress the type of measurement scale for each of the variables considered in the questionnaires. The next step was to examine each variable separately for suitability for univariate analysis, for example demographics and group composition, or multivariate analysis such as attributes of shared learning.

The questionnaires were designed to provide a profile of the curricula and the groups who shared learning environments. They contained nominal and ordinal data to facilitate completion of a relatively large set of data and to allow quantitative measurements in data analysis. Scales of precisely 10 points and attitudinal scales were used to extract the participants' perceptions of shared learning and to compare the results across questionnaires.

Triangulation of data analysis from the viewpoints of course leaders, student teachers, newly qualified teachers, and other teachers was achieved using descriptive statistics on nominal and ordinal data, and in comparisons across descriptive accounts within the themes presented in the qualitative findings.

Independent sets of data were subjected to cross-analysis of variables using the t-test for independent samples and correlation coefficients to identify the significant level of association between scores. Spearman's correlation coefficient was used to examine associations between scores. The nature of non-

parametric data and the low response rate in some components of the study inhibited any further statistical analysis.

4.8.3 Qualitative Data Analysis

The introduction of an innovation such as interprofessional shared learning has created interest nationally and many educational programmes have been implemented. Research has been carried out on many of these programmes with reported accounts of evaluative methods. However, the outcomes of research are constrained by where we look and how we look (Aldag & Searns 1988).

Bryman & Burgess (1994) summarise the difficulties in analysing and reporting qualitative data. In congruence with their views, the researcher adopted a framework that aims to articulate the processes involved in developing themes from the data with a systematic structured approach. Drawing on the methods applied to qualitative data analysis (Beck 1994), the data was transcribed, coded and categorised in accordance with the principles of qualitative design.

'The Framework' described by Ritchie & Spencer (1994) was chosen as the focus for structuring and organising the analysis. This approach was particularly apt to combine the innovation properties and the structure, process and outcomes surrounding the assessment, planning, implementation and evaluation of IPE. The research questions in data collection fitted the context of contextual, diagnostic, evaluative and strategic categories (Ritchie & Spencer 1994). At the familiarisation/orientation stage, it allowed the researcher to become familiar

with the range of responses and the variability of responses. The ACCESS database was extremely valuable in clustering qualitative data.

Developing a conceptual framework to sort, code and map patterns was not quite so straightforward as no previous work in this area could be replicated. Accordingly, a model to assist in data analysis was derived from other researchers' reports.

Dunkin & Biddle (1974) devised a conceptual framework for the study of classroom teaching. This model has the classroom as a focal point (*process variables*) with three sets of variables that influence the classroom events. Firstly, variables associated with the teacher are called *presage variables*, which signify the teacher's formative experiences, teacher training experiences, and teacher properties. The latter includes traits such as personality, knowledge and skills. Secondly, the variables associated with the student group(s), the classroom and community contexts are known as *context variables*. Lastly, the variables relating to the outcomes of education are known as *product variables*. Tuohy (1999 p137) relates to these aspects as:

- Product: the way in which learning is defined
- Process: the motives and strategies used by students to engage in learning. It also refers to the way in which teachers motivate students to learn, and how they teach them about learning.
- Presage: the context of learning, based on the personal dispositions of the learner and the institutional context of how learning is organised and valued.

This framework is a useful tool in data analysis, however there were limitations in using this model to analyse the qualitative data in this thesis. The problem lay in using a framework that only applies to the teaching and learning context when the *innovation* itself, IPE, also requires analysis within the context of teaching and learning.

More recent teaching and teacher evaluation profiles have been channelled through quality audit and assessment within higher education. Aylett & Gregory (1996) evaluated the available tools and suggested that there are four major components to evaluating teaching in higher education. These were described as, the approach to teaching; the delivery of teaching; outcomes of teaching; and recognition of the academic. It is suggested that these four components should be evaluated within the institutional context.

In contrast to Dunkin & Biddle (1974) these construct profiles address teaching variables only. However, these frameworks have a common ground, that is, they address the structure, process and product model. The latter seemed insufficient to set the *innovation* in context so it was decided to use a combination of tools to create the conceptual framework.

Similarities in variables used in Dunkin & Biddle's Model (1974) were noticed in the examples for sorting and coding given by Miles & Huberman (1994). These were used as the basis for the model of analysis with the extension of components from Aylett & Gregory's (1996) work, along with other components from the literature used in the background to the research questions.

The completed framework for coding and sorting data is demonstrated in Figure 4.3. This framework shows the identified variables against the contextual, diagnostic, evaluative and strategic categories formed for the questions posed within the research. The specific research questions on IPE and shared learning were categorised for each stage of the study. The questions at the familiarisation stage reflected the contextual or the *form and nature of what existed.* The exploratory, or investigative stage, involved the diagnostic questions to identify the *reasons for, or causes for what existed* while the explanatory stage focused on *the effectiveness of what existed.* The final stage of the study sought to review the situation and the questions posed reflected the strategic context of IPE and sought to *identify new theories.*

Once coding and sorting and charting of data was completed the researcher sought to define concepts, map the nature and range of phenomena, develop typologies, find associations and explanations, and develop strategies for policy implication. The final stage of data analysis combined the results from quantitative and qualitative analysis to structure a picture of IPE and the role of the teacher within the context of such.

Figure: 4.3 Framework for Data Analysis

	Contextual	*Diagnostic*	*Evaluative*	*Strategic*
	Form and nature of what exists	*Reasons for or causes for what exists*	*Effectiveness of what exists*	*Identify new theories*
Institutional Context				
1. *Background Institutions* Teacher Education Institutions Colleges/Schools of Nursing & Midwifery Universities & Other Departments 2. ***Background Academic*** Teaching within the Institutions Approach to Teaching and Learning Management of Teaching Evaluation of Teaching and learning Recognition of role of teacher				
Innovation Properties (IP)				
IP Organisation IP Definition IP Components IP Ideology IP Objectives IP Promotion IP Implied Changes-Classroom IP Implied Changes-Practice IP Implied Changes Organisation				
External Context (EC)				
EC Demographics EC Curriculum Structure EC IPE Framework EC Collaboration EC Partnership				
Internal Context (IC)				
IC Teacher Formative Experience IC Teacher Formal Preparation IC Teacher Properties IC Student Entry Behaviour IC Student Preparation IC Structural Aspects of Group IC The Environment IC Policy Implication				
Adoptive Processes (AP)				
AP Motives AP Typology of Teacher AP Teaching Models AP Teaching Strategies AP Types of Learning AP Learning Models AP Group Processes AP Dynamic between Groups AP Social Influence in Groups AP Theory Practice Links AP Role Identity AP Co-operation and Conflict				
Site Dynamics and Transformation (TR)				
TR Changes in Innovation TR Effects on Organisational Practice TR Effects on Organisational Climate TR Effects on Teaching & Learning TR Benefits & Barriers in Implementation				
New Configuration & Ultimate Outcomes (NCO)				
NCO Needs & Challenges for Innovation NCO Shifting the Paradigm for IPE NCO Implications for Collaboration NCO Policy Implications NCO Professional & Interprofessional Perspectives NCO Models & Challenges				

Chapter 5

Quantitative Data Analysis

Introduction to Chapter

This chapter discusses the results of the data from the three surveys. Initially, results from the questionnaire to course leaders within the teacher preparation centres are outlined. The next section discusses the results from an evaluation of the new teachers' perceptions of their teacher preparation in these centres. In addition, the questionnaire identified their role and impressions of shared learning when they took up employment afterwards. The final section is an analysis of the data retrieved from the questionnaire to teachers who were involved in IPE in higher education. A comparison of results from the three surveys concludes the chapter.

5.1: Survey of Institutions for Nurse /Midwifery /Health Visitor Teacher Education in England

Teachers of nurses, health visitors and midwives are more closely aligned to schoolteachers than any other teachers in health or social care professions in that they are obliged by their statutory body to qualify and register as teachers (UKCC 1988; 2000). The centres that participated in this study were validated by the ENB as centres for nurse, midwifery and health visitor teacher education. From a historical viewpoint, health visitors and midwives were restricted by the nature and availability of preparation courses for teaching within their own discipline and several anomalies surrounded the structure of programmes, in particular the

generic nature of a nursing qualification. Health visitors had to abide by certain policy regulations to obtain both Registered Nurse Teacher (RNT) and Teacher in Health Visiting awards. This meant an extra 40 days practice in nursing education and attending two practice settings. Later on, centres began to facilitate courses that awarded a teaching qualification specific to specialist areas of professional practice. Changes in policies for the preparation of health visitor teachers were welcomed. The National Boards for England, Scotland, Wales and Northern Ireland validate and monitor programmes for nurse's midwives and health visitor teacher education on behalf of the UKCC.

The ENB Educational Policy Research and Development Department sought guidance on the relevance and appropriateness of shared learning for teacher preparation and recommendations of models and definitions of 'good practice' in shared learning for teacher preparation. The next section examines the data from Survey One. The data in this first survey was used to inform policy makers (ENB 1995b) on shared learning in teacher preparation programmes. The data is organised to identify the structure and policy of education for student teachers, the processes as viewed by the programme leaders and their perceptions of results.

The questions were framed around certain categories which are outlined in Figure 5.1.

Figure: 5.1 Questions for Survey One

The questions were framed around the following categories:

- Nature of the programme(s)/curriculum content/group composition
- Promotion of shared learning
- Objectives/Goals for Innovation
- Collaboration/Validation
- Preparation of staff and students
- Perceptions of staff and students
- Evaluation of shared learning
- Benefits and Barriers
- Open comments

5.1.1 ENB Structure and Policy of Teacher Education

In 1993, the ENB began the task of gathering data towards workforce planning requirements for teachers. The aim was to assess best practice in funding teacher education for nurses, midwives and health visitors. At the time the national picture showed a decline in demand for newly qualified teachers. Predisposing factors were the imminent amalgamation of Colleges of Nursing/Midwifery and the integration of these Colleges into Higher Education.

The ENB (1993) documentation identified varied programmes for nurses, midwives, health visitors, district nurses and occupational health nurses to obtain a teacher qualification through part-time and full-time programmes. These programmes were delivered through Universities, with three exceptions where the HE institutions had yet not gained the title of University. On successful completion the professionals could register their qualification with the ENB. Figure 5.2 shows the type of programmes on offer within 20 institutions.

Figure: 5.2: Programmes Validated by the ENB (1993) for Teacher Qualification for Nurses, Midwives, Health Visitors

Type of Programme	College/ University	Length years	Mode (F) Full time P (Part-time)	Profession
Certificate Education	A, B, C, D, E	1 2 2	F P F/P Sandwich	Midwives/ district nurses midwives midwives
Cert .Education (FE)	F	2	P	midwives
Cert .Education Teachers	G	1	F	Health visitors
Diploma in Adult Education	H	1	F	midwives
B.A Nursing Education	J	4	F/P	Health visitors
B.A (Hons) Nursing Education Studies	K	2	P	
B.A. Combined Studies of Health & Education	D	2	P	Midwives
B.A Midwifery Education	J	4	F/P	Midwives
B.A (Hons) Midwifery with Education	L	2	F	Midwives
B.A (Hons) Midwifery Education Studies	K	2	P	Midwives
B.A. (Hons) Health Care Professions	M	2	F	Midwives
B.A (Hons) Nursing with Education	L	2	F	
B.Ed. (Hons) Nurse Teachers	N	2	F	
B.Ed. Teachers of Midwifery	D	2	P	Midwives
B.Ed. (Hons) Teachers of Nursing	D	2	P	
B.Sc. (Hons) Nursing with Education.	O, P	2 3	P F	Health visitors district nurses
B.Sc. (Hons) Nursing Education	J,Q	2	F	
B.Sc. (Hons) Education Studies	E E	2 4 terms	P F	
B.Sc. (Hons) Nursing Studies Teaching & Learning Option	R	2	P	
B.Sc. (Hons) Nursing with Education	O,P	2 3	P F	
B.Sc. (Hons) Midwifery with Education	P	3	F	Midwives
B.Sc. (Hons) Education Studies	E	4 terms	F	Midwives
Post Graduate Diploma in Education	J, M	1	F	Midwives Health visitors/district nurses
Post Graduate Diploma in Adult Education	S	2	F	
PGCEA	T	1	F	Midwives/Health visitors/district nurses occupational health nurses
PGCE	B, E, U, L, U, D E	1 2 4 terms	F P F	Midwives/ Health visitors District nurses

Note: To respect confidentiality the institutions are represented by letters of the alphabet.

Although some programmes were listed specifically for midwives/health visitors/district nurses/occupational health nurses, it was also stated that all the programmes listed for nurse teachers were open to them.

Figure 5.2 shows that nurses, midwives and health visitors who wished to progress to teaching their discipline could qualify through different academic levels. The Certificate in Education was the most frequent route until concurrent policy changes (UKCC 1986) introduced Project 2000, diploma level educational programmes for pre-qualifying education and recommendations that teachers be prepared at graduate level. These changes accounted for the decline in certificate programmes and an increase in validation of Bachelor degrees and above.

5.1.2 Organisational Context for Teacher Education

Out of 20 institutions on the ENB approved list of programmes 17 centres were running programmes. A comparison between the ENB document and telephone contact with the centres showed that a new centre had gained validation (W) since document publication. A postal questionnaire was forwarded to these 17 centres. Twelve complete responses were returned. It is acknowledged that the sample size invalidates the application of most statistical testing. Descriptive statistics and percentages are used to put the variables into context. Non-parametric statistical tests were used as appropriate for nominal and ordinal data. Any discrepancy in response to individual statements or questions is due to incomplete data sets when some respondents did not complete a section.

FIGURE: 5.3: ENB Validated Programmes Within Teacher Education Centres

Centre	Programmes	Mode: Full time (F) Part time (P) M=Mixed	Is Shared Learning an option on this course?	Approximate % of course involving shared learning	Professions sharing learning
1 (B)	Post Graduate Certificate in Education (PGCE) Certificate in Education	F	no	15% =60 hours	Nurses, midwives, all BEd. students
2 (P)	BSc (Hons) Nursing with Education MSc/Post Graduate Diploma Health Professional Education	F F and P	yes	Not completed	Nurses, midwives, health visitors
3 (K)	BA Nursing / Midwifery with Education Studies	P	no	Not completed	Nurses, midwives, health visitors
4 (W)	BA Nursing Education BSc Nursing with Education Post Graduate Diploma in Education Diploma in Nursing Education and Practice Overseas	M M F F	Yes No yes	80%	Nurses, midwives, health visitors, BA and BSc students education modules
5 (M)	BEd (Hons) in Education Studies Post Graduate Diploma in Education Studies for Health Professionals	F P	No yes	35%	Nurses, midwives, health visitors social workers and others
6 (U)	PGCE Health Professional	F and P	yes	100% for health professionals 90% share with non-health professionals	Nurses, health visitors physiotherapists, social workers, occupational therapists radiographers, counsellors, chiropodists
7 (N)	BEd (Hons) Nurse Teachers PostGraduate Diploma in Education (Health Professionals)	P P	yes	100% (20%) in tutorials)	Nurses, Nurses midwives, health visitors physiotherapists, social workers, occupational therapists, others
8 (L)	BA (Hons) Nursing/Midwifery with Education PGCE Nursing Post Graduate Diploma/MA Health Professional Education	P P Pand F	Yes Yes New course	100% 75%	Nurses, midwives, health visitors physiotherapists
9 (S)	PostGraduate Diplom in Education for Professional Health Care Practice PostGraduate Diploma in Advanced Health Care Practice	P and F P and F	no	70% all class contact time	Nurses, midwives, health visitors, physiotherapists, social workers, occupational therapists (open to all)
10 (F)	BEd (Hons) Higher Education PostGraduate Diploma Higher Education	P and F		Not completed	Nurses, midwives
11 (D)	BEd PGCE	P P	Yes yes	100% both programmes function as one	Nurses, midwives
12 (J)	PostGraduate Diploma in Education (Nursing, Midwifery, Health Visiting) BA (Hons) Nursing Education	PTand F P and F	Yes Yes	70% 65%	Nurses, midwives, health visitors

The programme(s) on offer at each centre are shown in Figure 5.3. The range of programme titles indicate that, at the centres involved in the study, it was possible to prepare as a teacher in nursing, midwifery and health visiting by a variety of full time and part time routes ranging from degree (nine courses) to Masters degree (two courses). The number of Post Graduate Diploma (P.G.Dip.) courses matched the number of degree programmes. One centre (9) cited more than one programme at this level and four centres (1, 6, 8, 11) noted that they offered a Post Graduate Certificate in Education (PGCE) programme. This pattern of post graduate programmes for teacher preparation indicated that nurses, midwives and health visitors were entering preparation programmes at graduate level.

It was evident from the comments made by the participants that pathways for teacher preparation were through modular matrix systems now established in higher education. Figure 5.3 shows that five centres had nurses, midwives and health visitors only within shared learning environments, however, one of these centres stated that the potential to share with others was available. When these professionals shared learning milieu, the named health and social care professions were social workers, physiotherapists, occupational therapists, radiographers, counsellors and chiropodists. Some of the programmes were open to all student teachers from any profession. One centre used the term collaborative learning, while another centre was in the process of validating four programmes at Masters level, one of which was interprofessional studies.

Only four centres indicated that shared learning was not an optional factor, instead it was integral to the programme. Six centres stated that shared learning was

optional while two centres illustrated that it was programme dependent. Overall, nine centres indicated that shared learning ranged between 15% of the programme to 100%.

The situation became more meaningful in the answer to the question 'did the curriculum promote shared learning?' Responses from 11 of the 12 centres indicated that shared learning was promoted within their curriculum. The nature of the questionnaire meant that the remaining questions were invalid to the participant who perceived that shared learning was not promoted. Thus, eleven centres make up the representative sample in the remaining analysis of this survey. The questionnaire aimed to identify the number of student teachers undertaking these programmes. The number of course leaders who could not readily access this data meant that the results could not be computed.

5.1.3 Objectives for Shared Learning

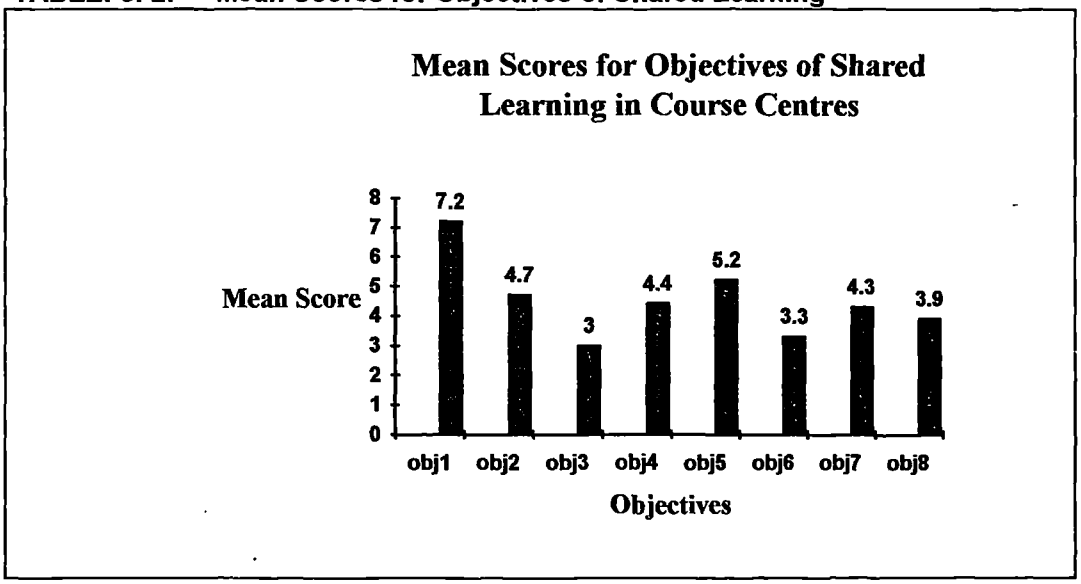
A number of different objectives of shared learning were identified from the literature and respondents were asked to rank these in order of their perceived importance with a score of 1 being the most important and a score of 8 being the least important. The responses to this scale can be seen in Table 5.1. The nominal data in this table gives the number of responses to each ranked score. Due to the sample size percentages are not identified. At a glance, Table 5. 1 shows that that half of the course leaders viewed effective and efficient use of resources as most important. The mean scores for each of the objectives above are identified in Table 5.2. These mean scores give an indication of the location of the average scores.

TABLE 5. 1: Ranked Scores for Shared Learning Objectives (scale of 1-8)

Objective No.	Shared Learning Objectives	Scale							
		1	2	3	4	5	6	7	8
1	To develop practical skills	0	0	2	0	1	4	3	1
2	To prepare student teachers for future career prospects	0	1	3	3	1	1	0	2
3	To increase interdisciplinary understanding and co-operation	0	2	2	1	1	1	1	3
4	To break down language barriers between disciplines	0	3	1	2	1	2	1	1
5	To provide effective/efficient service for consumers	2	1	3		1		3	1
6	To provide theory and practice learning opportunities	0	1		3	2	2	0	2
7	To produce competent interdisciplinary teachers	3	3		2	2	1	2	0
8	To make effective/efficient use of resources	6	0	0	0	2	0	1	1
TOTAL		11	11	11	11	11	11	11	11

(Key to rating scale: 1= most important, 8= least important)

TABLE: 5. 2: Mean Scores for Objectives of Shared Learning



As seen from Table 5.2, the three highest ranked objectives (i.e., with the lowest mean scores), were: to increase interdisciplinary understanding and co-operation; to provide theory and practice learning opportunities; and to make effective and efficient use of resources.

Kendall's coefficient of concordance showed only two significant associations between the ranked scores. A positive association was computed between increasing interdisciplinary understanding and co-operation, and breaking down language barriers between disciplines (Kendall's test: df = 9; r = .7021; p = 0.4 two-tailed test). A negative correlation was computed between preparing student teachers for future career prospects and producing competent interdisciplinary teachers (Kendall's test: df = 9; r = -.6042; p = 0.02). A larger sample would give a clearer indication of common understanding between centres regarding the objectives of shared learning.

5.1.4 Goals for Shared Learning

Participants were asked to rank in order of importance (1=most important 6= least important) the following goals for shared learning:

1) Review/credit award systems
2) Develop a curriculum model/framework
3) Enhance teaching/learning strategies
4) Develop teachers for their role
5) Extend shared learning initiatives
6) Promote existing shared learning initiatives

The mean scores for shared learning goals are outlined in Table 5.3 and show that the highest ranking goals were to develop teachers for their role and enhance teaching and learning strategies. A correlation between ranked scores was not significant as no correlation equalled or exceeded the required statistical value (df =•549). An examination of the data showed an equal number of respondents stated that their main goal in promoting shared learning was to enhance teaching and learning strategies and develop teachers for their role. It was recognised that institutions also had to address cost-effectiveness.

5.1.5 Collaboration

The course leaders were asked to identify who collaborated in the provision of shared learning initiatives. The results (Table 5.4) showed that the main collaboration was between representatives of higher education and colleges of nursing and midwifery. Other organisations who collaborated were the ENB, for validation purposes, active researchers in professional practice and education, and professional leaders in the multi-disciplinary health care team, such as physiotherapists and other paramedical groups. The respondents were also asked to indicate the nature of the collaboration. As can be seen in Table 5.5 the main focus of collaborative work was on conjoint validation of programmes. There was a positive association between conjoint validation of programmes and recruitment of students (Kendall's test; df = 9, r = .7255; p = 0.05, two-tailed test). There was also a positive association between the scores from those institutions collaborating in evaluating programmes and the preparation of staff for their role (Kendall's test df = 9; r = .6154; p = 0.05, two-tailed test).

Table: 5.3: Mean Scores for Shared Learning Goals

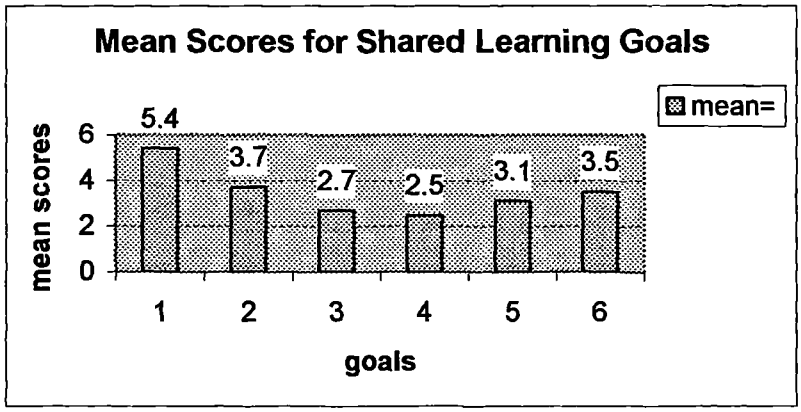


TABLE: 5.4 Collaborating Bodies in Provision of Shared Learning

Collaborative Bodies	Number of Responses
Service managers/representatives	5
Higher education representatives	10
Nursing/Midwifery professional organisations	8
N.C.V.Q. (teaching and assessing)	0
Others: ENB (for validation) Colleges of Nursing/Midwifery. Researchers in professional practice and education Professional leaders from different disciplines	4

TABLE 5.5: Nature of Collaboration for Shared Learning Initiatives

Collaboration	Number of Responses
Conjoint validation of programmes	10
Recruitment of students	9
Monitoring courses	9
Assessment of students	8
Evaluation of courses	8
Conjoint development of educational policies	7
Preparation of staff for their role	6
Other (s)	

5.1.6 Preparation for Shared Learning Environments

Nine respondents stated that teaching staff and students were prepared for their role in shared learning environments. On a 10 point scale the mean score for teacher preparation was 5.5 and for student preparation a mean of 6.2, thus suggesting a level of preparation slightly above the average.

Respondents were also asked to indicate on a 10 point scale how the staff (teachers) in the teacher preparation centres and students undertaking teacher preparation courses perceived shared learning. Results gave a mean of 8.3, indicating that the staff were generally in favour of shared learning, and a mean of 6.6 for students, which also suggested a favourable orientation.

5.1.7 Implementation of Shared Learning

The study aimed to evaluate how shared learning was promoted and integrated into the curriculum for teacher preparation. Eleven centres promoted shared learning. Teachers undertaking these programmes had to demonstrate their teaching ability in the classroom and undergo assessment of the same. Part of the programmes incorporated the regulations of practice teaching in other establishments. This meant that student teachers had supervised teaching either in colleges/departments of nursing and midwifery, and/or partly within further education colleges.

An indication as to where shared learning is incorporated into the curriculum can be seen in Table 5.6. Five centres incorporated shared learning into theory and practice and the remaining six into theoretical aspects only. However, there may

have been a discrepancy in the interpretation of 'practice' in this instance. This confusion seems to stem from the terms 'practice in teaching' and 'clinically based practice'.

The learning outcomes were the same for all disciplines within seven centres. Four centres had distinct learning outcomes for different disciplines. Different award systems on completion of the programmes were noted in three centres. The rationale given for this was that teaching qualifications could be recorded on different parts of the professional register held by the UKCC. It was also noted that in some modular type programmes the awards could differ.

The assessment processes were the same for all disciplines within all but two centres. However it was noted that whilst the assessment processes were the same in some centres, the actual assignment topics were individualised and negotiated between tutors and students.

5.1.8 Evaluation methods

Shared learning outcomes were evaluated in nine centres and one centre proposed to do so in the near future. Participants were asked to rank in order of importance evaluation methods most salient in the centre. All eleven participants ranked feedback from students as most important, with feedback from course teachers as second most important in their organisation. Feedback from clients in clinical practice was ranked as least important alongside audit reports suggesting that shared learning was not necessarily planned for practice settings (see Table 5.7).

One centre viewed all of these as equally important mechanisms. The responses could reflect that interaction between teachers in educational establishments and clients in relation to shared learning was not the norm. Feedback did occur through ENB auditing of clinical placements. Other feedback mechanisms were through student surveys, evaluation questionnaires at the end of each term, nominal group technique, faculty yearly monitoring reports and external examiner reports. Kendall's coefficient of concordance showed no significant association between scores.

TABLE 5. 6: Integration of Shared Learning in Curriculum

Course Content	Responses
Theory & Practice	5
Theory only	6
Outcomes Same	7
Outcomes Distinct	4
Assessment Same	9
Assessment Distinct	2
Awards Same	8
Awards Distinct	3

TABLE 5.7: Methods of Evaluating Shared Learning

Evaluation Mechanism	Responses
Feedback from students	11
Feedback from course teachers	8
Changes in course teacher's professional performance	4
Competency-based outcomes	3
Feedback from clients (if shared learning occurs in practice setting)	2
Audit reports	2
Other (s)	5

5.1.9 Summary of Survey One

The survey of the centres preparing teachers of nursing, midwifery and health visiting served to provide a broad illustration of the way in which course centres approached shared learning in teacher preparation programmes. This initial stage of the research targeted all of these centres through a survey design which resulted in the return of 12 questionnaires. The questions reflected the policy issues of relevance at the time.

In general, it was concluded that the range of programmes offered within the centres created opportunity to facilitate shared learning in teacher preparation. However, most of the programmes reflected multiprofessional education as opposed to interprofessional education.

The sample of participants (n=11) based on a population of seventeen placed limits on how the quantitative data could illustrate comparisons between findings. The developmental nature of this evaluation is evident when the analysis of this survey is compared to the analysis of survey three. The latter included a larger sample and refinement of variables to accommodate new evidence. This initial survey was necessary to identify the extent of shared learning in teacher preparation. The interview data from course leaders in five case studies, chosen to illuminate the results are discussed in Chapter 6.

5.2 New Teachers' Impressions Of Their Preparation And Role

The next stage of the research involved a survey of teachers who had recently completed the teacher programme at the five case study centres. The questionnaire was designed to generate data in relation to the new teachers' perceptions of their shared learning experiences on teacher preparation programmes, and to evaluate the respondents' perceptions of their own teaching role in facilitating shared learning in their role as new teachers. Questionnaires were sent to 143 newly qualified nurse teachers. Sixty questionnaires were returned (42%) and of these two were omitted from the analysis due to incomplete data. Consequently the results are based on the analysis of 58 completed questionnaires (40%). Figure 5.4 shows categories for the questions in survey two.

Figure 5.4 Questions for Survey Two (Part 1)

Specific questions for the first part of the questionnaire were framed around the following categories:

- Profile of new teachers
- Profile of the new teachers' preparation programmes
- New teachers' perceptions of shared learning/teacher preparation/personal views
- New teachers' perceptions of attributes of shared learning

5.2.1 Demographic Details of Respondents

Respondents included forty six woman (79%) and twelve men (21%). The majority of participants (30%) were within the 36 to 40 year age range (Table 5.8). The analysis of the data indicated that due to the variety of courses on offer across centres, including full time and part time courses, the new teachers had completed their programmes at different dates. Cross analysis of variables was

undertaken using the t-test for independent samples to identify whether the responses from the sample varied depending on the date of commencement and date of completion of teacher preparation programmes. There were no significant findings from this analysis.

New Teachers' Specialist Field

The majority of respondents were teachers in nursing, midwifery or health visiting. Four respondents were not health care professionals. However, the findings from this group of non-health care professionals did not differ significantly from the main group and so this data was included in the final analysis, as the focus was on teacher preparation in a shared learning environment.

The specialist curriculum areas of respondents are summarised in Table 5.9. Nurses were from various branches within the discipline and the number of Health Visitors and Midwives in the study is a reflection of the total sample within the centres. Seven respondents gave other curriculum areas such as further education, design, sports, leisure and tourism, history and complementary medicine.

TABLE 5.8: Age Range of New Teachers

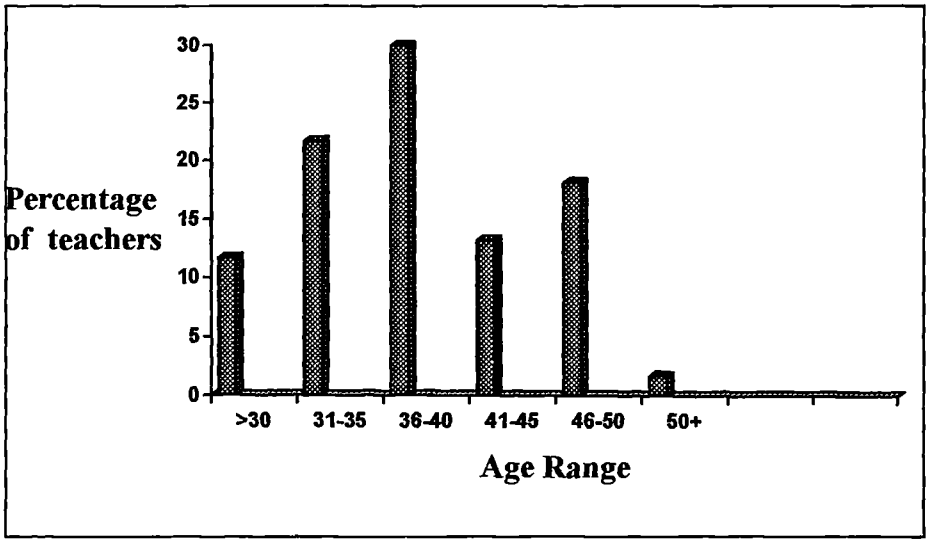


TABLE: 5.9: New Teachers' Area of Professional Expertise

Curriculum area	No of Responses
Nursing (various)	43 (74%)
Midwifery	4 (7%)
Health Visiting	4 (7%)
Other (s)	7 (12%)
Total	58 (100%)

TABLE: 5.10: Preparation Programmes Completed by new Teachers

Type of Course	Responses	Part time	Full time	Mixed Mode
PGCE/Cert Ed	11 (19%)	7	4	
PGCE	2 (3.5%)	2	0	
BSc (Nurse Education)	10 (17%)	1	9	
MSc Diploma Health Professionals	1 (2%)	0	1	
BA Nursing/Midwifery Education	2 (3.5%)	1	1	
Post Grad Diploma in Education	10 (17%)	0	10	
BEd (Hons)	18 (31%)	4	14	
*Others	4 (7%)	1	2	1
Total	**58(100%)**	**16(27%)**	**41(71%)**	**1(2%)**

TABLE 5.11: Frequency of Professionals in Shared Learning in Teacher Preparation

Response	Nurses	Midwives	Health Visitors	Physio-therapists	Social Workers	Occup/ Therapists	Others
Yes	55(95%)	46 (79%)	41(71%)	4 (7%)	5 (9%)	1 (2%)	20(34%)
No	3 (5%)	12 (21%)	17(29%)	54 (93%)	53 (91%)	57 (98%)	38(66%)
Total	**58**	**58**	**58**	**58**	**58**	**58**	**58**

5.2.2. Structure and Policy of Teacher Education

Teacher Preparation Programmes

The type of teacher preparation programme at each centre was identified. Table 5.10 shows the programmes undertaken by respondents. The most common course was the BEd.(Hons) full time.

Composition of Shared Learning Groups

The teachers were asked to state which professions shared the learning milieu. The results in Table 5.11 indicate that for the most part, nurses, (including community psychiatric nurses and district nurses) midwives and health visitors shared learning within the teacher preparation programmes in the five centres. However, twenty respondents (33%) stated that a range of other professional groups were also involved in shared learning environments. These professional groups consisted of educators from a range of occupational groups prepared in Further Education and Higher Education institutions, such as police officers, carpenters, electricians, builders, plumbers, plasterers, biologists, chemists engineers, administrators and medical artists. The percentage of other health and social care professionals was smaller than that of professionals outside of health and social care.

Promotion of Shared Learning within Teacher Education

Respondents were asked to rate on a 10 point scale how their teacher preparation centre favoured shared learning. The mean score on this scale was 3.9 indicating that new teachers did not think these centres were strongly in favour of shared learning. This was a lower score than that awarded in the survey of all the course

centres. In contrast to this, using the same scale of measurement, the new teachers perceived that they themselves were generally in favour with a mean score of 7.2. The written comments indicated the positive and negative perceptions of shared learning as identified by the participants. These are analysed in Chapter 6.

Curriculum Context

The respondents were asked to identify aspects of the curriculum that were common to all group members. The researchers sought to identify whether theory and teaching practice were shared elements and if the learning outcomes and assessment processes were the same or distinct for subgroups. Table 5.12 shows that most respondents had experienced sharing of theory and teaching practice within a classroom environment.

Participants' comments indicated that 'practice' in this instance was interpreted as practice teaching in the classroom rather than practice in their own professional area. Descriptive evidence suggested that sharing of experiences did not take place in practice placements as student teachers were allocated to their own specialism. Even when student teachers were afforded the opportunity to teach outside of their own professional specialism this was difficult to arrange. In some instances sharing of ideas occurred only on an informal basis outside the classroom, and that shared learning did not appear to be a planned part of their teacher preparation programme. Sharing in the classroom gave them cognitive insight into other members' experiences, especially through seminar presentations and open discussions as indicated by the following comment:

Midwives and health visitors were less represented in some groups but their perspective was appreciated by other group members and their contribution was valued in reducing barriers between community and hospital environments.

> *I found the midwives and health visitors gave a different perspective and were very autonomous and health oriented. This made for interesting discussion both in class and at breaks. Although they were a minority in the group, it was not a problem as their contribution was recognised* (nurse teacher).

Giving examples to meet all group members' specialist needs presented as a problem for some:

> *The minority group of midwives and health visitors seemed ambivalent. Sometimes feeling they were happy. Sometimes the feeling was most examples of practice were more nursing oriented than relating to their practice* (midwifery teacher).

Recognition of facilitation clearly influenced the minority group members' perceptions as indicated in the following statement:

> *If the teacher is from a similar background to the majority of the group the 'language can become very closed and club like'. This creates a feeling of exclusion at times the course content can seem irrelevant to our needs. The teachers need to be more adaptable* (health visitor teacher).

Learning Outcomes Assessments and Awards Systems

The new teachers perceived that the learning outcomes, assessment procedures and award systems were generally the same for all group members within the five centres (see Table 5.13). Although the learning outcomes and assessment procedures were the same in all centres, the assignments related to the individual's own area of specialism. It was suggested by some respondents that the practical assessment strategies in teaching could pose problems for a new teacher with a

own area of specialism. It was suggested by some respondents that the practical assessment strategies in teaching could pose problems for a new teacher with a community focus. However, community-oriented respondents did not perceive this as a problem because these were mostly related to classroom teaching. They suggested that the nature of the programme allowed the sharing of ideas and also freedom for the individual to pursue their own interests, especially through the assessment processes. Peer assessment was appreciated and assisted shared learning in the practice of teaching.

5.2.3 New Teachers' Evaluation of Preparation for Their Role

Respondents were asked to rate the statements in Table 5.14 regarding their teacher preparation through shared learning. The results indicate that most new teachers felt quite well prepared to develop teaching strategies, motivate mixed groups and develop curriculum frameworks. There was a rather less positive response to the statement relating to meeting the needs of minority groups. Spearman's correlation coefficient indicated a highly positive correlation between the scores for each statement ($p=0.05$ two tailed test).

Additional comments from some respondents indicated that there were other positive features in their teacher preparation programme that had contributed towards their understanding of shared learning and helped them to accomplish skills which are identified in Table 5.15.

TABLE: 5.12: Frequency of Shared Elements in Programme Content

No. of Responses	Theory & Practice	Theory Only	Practice Only
Yes	34 (59%)	19 (33%)	1 (2%)
No	21 (36%)	36 (62%)	54 (93%)
N/A	3 (5%)	3 (5%)	2 (5%)
Total	**58**	**58**	**58**

Table 5.13: Integration of Shared Learning in Curriculum

Number of Responses (n=58)	Outcomes same	Outcomes distinct	Assessment same	Assessment distinct	Awards same	Awards distinct
Yes	50 (86%)	5 (9%)	53 (91%)	4 (7%)	50 (86%)	7 (12%)
No	5 (9%)	50 (86%)	4 (7%)	53 (91%)	7 (12%)	50 (86%)
Not answered	3 (5%)	3 (5%)	1 (2%)	1 (2%)	1 (%)	1 (2%)

TABLE: 5.14: New Teachers' Perceptions of Preparation for Particular Teaching Tasks

Statement	Very well	Quite well	Uncertain	Poorly	Not at all
Developing teaching strategies	10 (17%)	27 (46%)	4 (7%)	8 (14%)	4 (7%)
Motivating mixed groups	8 (14%)	24 (41%)	4 (7%)	12 (21%)	6 (10%)
Meeting needs of minority groups	8 (14%)	15 (26%)	12 (21%)	12 (21%)	7 (12%)
Providing relevant examples for learners	6 (10%)	24 (41%)	8 (14%)	9 (15%)	7 (12%)
Developing curriculum frameworks	10(17%)	23 (40%)	5 (9%)	9 (15%)	7 (12%)

TABLE: 5.15:
New Teachers Additional Preparation through Shared Learning Environments

Comments:
Teaching health professionals
Encouraged creativity and personal reflection
Meeting the needs of disadvantaged
Overcoming cultural and generation gaps including class differences and gender
Awareness of different learning styles
Leading specialist seminars
Facilitative approaches
Exploring/assessing learning needs
Understanding reflection and experiential learning

5.2.4 Summary of Part One of Questionnaire

This component of the questionnaire explored the new teachers experience of shared learning in their teacher preparation programmes and indicated a favourable response towards the benefits of shared learning.

There was a level of consistency between what the new teachers noted about their programmes and the findings from the survey of course centres. Contrasting views were recorded in two particular areas. These were the perceptions held by the new teachers about the way the teacher preparation centres favoured shared learning and the ways in which the needs of minority groups were addressed.

The results indicate that most new teachers felt well prepared to develop teaching strategies, motivate mixed groups and develop curriculum frameworks. There was a rather less positive response to the statement relating to meeting the needs of minority groups.

The next part of the questionnaire explored the extent to which these new teachers were able to utilise their knowledge in the environment of colleges of nursing and midwifery when they took up post as teachers on completion of their course.

Section 5.3 Role of New Teachers in Colleges

The remainder of the questionnaire aimed to identify the newly qualified teachers' perceptions of their own teaching role in facilitating shared learning as teachers in nursing, midwifery and health visiting. The focus was on shared learning environments and initiatives. Three respondents returned to clinical practice

without a formal teaching role and consequently did not answer to some questions. The questions for the second part of the questionnaire were framed around the categories in Figure 5.5.

Figure: 5.5 Questions for Survey Two (Part 2)

The questions were framed around the following categories:

- Initiatives in institution
- Evaluation of innovation
- Collaboration
- New teachers orientation to new position
- Preparation of teachers/students
- Adequacy of preparation for role
- Open comments

5.3.1 Professional Development Opportunities

A number of support mechanisms for newly qualified teachers were identified and new teachers were asked to indicate to what extent these had been available to them including if they had opportunity to teach in a shared learning environments (Table 5.16).

As seen from Table 5.16 over half the respondents had undertaken an induction programme on return to their own area, were allocated a mentor and were teaching in shared learning environments. However, relatively less participants had worked alongside an experienced teacher even though a majority did have a mentor. The mentor's role was sometimes ambiguous as indicated by the following statements:

No formal mentorship programme was offered. I just 'latched on' to an experienced teacher who seemed happy to have me 'tag along'. I would not have survived the first few months without her help (nurse teacher).

There was no specific preparation even the induction period was a series of meeting members of the institution as opposed to preparation for one's role in practice (nurse teacher).

Spearman's correlation (p=0.05) indicated positive correlations between the statements *undergo an inductive programme, work alongside experienced teachers,* and, *taught in shared learning environments.*

5.3.2 Preparation of Teachers and Students for Shared Learning

Thirty five (60%) respondents felt that teachers were not prepared for their role in shared learning environments and twenty eight (50%) felt that students were not prepared either. Others commented that they felt inadequately prepared to facilitate shared learning. This evidence contradicts the views of course leaders in teacher education.

Shared Learning Initiatives within Colleges of Nursing/Midwifery

Twenty seven (46%) respondents were aware of initiatives regarding shared learning within their own college.

Evaluation Methods

The respondents (22%) indicated that shared learning was evaluated within their colleges. This was achieved largely through end of term evaluations, including the use of questionnaires and oral feedback from students. However, a number (30%) did not know of any evaluative strategies. Others (29%) said that shared learning

was not explicit in evaluative strategies although students often referred to it in feedback sessions. It was recognised that where there was no formal mechanism, these colleges evaluated experiences by verbal feedback, conferences and the use of nominal group techniques. This was a similar response to the same question asked of the teacher preparation centres.

From their experiences, new teachers concluded that, although students in the colleges appreciated the topic structure, they did not always understand the relevance of shared learning to themselves. The new teachers themselves felt that the varied outcomes depended on the group dynamics, which were influenced by the background experiences and age of the student group. Shared learning in some cases was perceived by the new teachers to create fragmentation in learning due to structuring of programmes in the college. This led to a comment that delivery was no different to traditional approaches to teaching.

5.3.3 New Teachers' Perceptions of Shared Learning

Respondents were asked to rate their level of agreement with 16 statements (Table: 5.17), which were identified from both the literature review and data production from the course leaders.

TABLE 5. 16: Support Mechanisms for New Teachers

Support Mechanism	Yes	No	N/A
Did you undergo an induction programme?	35 (60%)	19 (33%)	4 (7%)
Did you observe different teaching styles?	28 (48%	25 (43%)	5 (9%)
Did you work alongside an experienced teacher?	21 (36%)	31 (53 %)	5 (9%)
Did you have a mentor?	37 (64%)	16 (27%)	5 (9%)
Did you teach in shared learning environments?	33 (57%)	19 (33%)	6 (10%)

TABLE: 5.17: New Teachers' Perceptions of Shared Learning Attributes

SHARED LEARNING:	SA	A	U	D	SD
Promotes mutual understanding of roles	27 (46%)	26 (45%)	4 (7%)	1 (2%)	0
Disadvantages minority groups	5 (9%)	15 (26%)	9 (15%)	24 (41%)	5 (9%)
Promotes creative teaching	21 (36%)	22 (38%)	8 (14%)	7 (12%)	0
Helps breakdown professional barriers	22 (38%)	31 (53%)	4 (7%)	1 (2%)	0
Limits teaching to principles of the topic only	3 (5%)	17 (29%)	7 (12%)	26 (45%)	5 (9%)
Enriches the learning process	22 (38%)	28 (48%)	6 (10%)	2 (3%)	0
Increases cost effectiveness	14 (24%)	27 (47%)	16 (28%)	0	0
Can provoke anxiety in students	2 (3%)	18 (31%)	10 (17%)	24 (41%)	4 (7%)
Enhances personal development	17 (29%)	30 (52%)	6 (10%)	5 (9%)	0
Dilutes specialist subject matter	13 (22%)	21 (36%)	3 (5%)	18 (31%)	3 (5%)
Encourages self-appraisal	11 (19%)	31 (53%)	10 (17%)	5 (9%)	1 (2%)
Causes problems in planning programmes	7 (12%)	17 (29%)	15 (26%).	18 (31%)	1 (2%)
Promotes collaborative teaching	14 (24%)	32 (55%)	8 (14%)	3 (5%)	1 (2%)
Requires specific preparation for teaching	7 (12%)	18 (31%)	16 (28%)	15 (26%)	0
Creates interdisciplinary rivalry	0	8 (14%)	8 (14%)	34 (59%)	8 (14%)
Is a cost cutting exercise	12 (21%)	7 (12%)	18 (31%)	19 (33%)	2 (3%)

KEY: SA= Strongly Agree, A = Agree, U = Uncertain, D = Disagree, SD = Strongly Disagree.

The responses in Table 5.17 above were analysed further to show possible associations between scores. Spearman's correlation coefficient was used with p = 0.05 as a level of significance for two-tailed testing on the sample. The results show, as anticipated, positive and negative associations between specific statements. As these results only indicate an association, not a causation of factors, their relationship is tenuous and is conveyed as such. However, some of the patterns in this analysis do provide a basis for further enquiry.

In general the pattern identified shows positive correlation between those statements identifying the positive features of shared learning and negative correlation with those illustrating negative features of shared learning. For example, the statement promotes *mutual understanding of roles* correlated positively with statements which attributed shared learning as encouraging self-appraisal and promoting collaborative teaching.

5.3.4 Summary of Part Two of Questionnaire

The findings from Part 2 of the questionnaire distributed to new teachers focused on the extent to which they were able to use the skills acquired in the teacher preparation programmes to facilitate shared learning. This data provided an indication of shared learning in colleges of nursing and midwifery in the context of teacher development and support in their new roles. Overall, the findings from this section indicated that shared learning initiatives were present in these colleges, however, student and teacher preparation was inadequate. The methods used to evaluate shared learning and the support new teachers received in their role as facilitators of shared learning were identified.

5.4 Views of Teachers in Higher Education

The third survey aimed to identify the interprofessional initiatives offered throughout the UK. The sample was extracted from the CAIPE database. Eight hundred and twenty five questionnaires were circulated to teachers in health and social care within England, Scotland, Wales and Northern Ireland. The returned completed questionnaires (n= 246) included a sample of various health and social care professionals but the majority of respondents were from nursing, midwifery and health visiting. The reasons for this are threefold:

1). Nurses, health visitors and midwives combined are the largest group of health professionals

2). Nurses were included in all programmes entered in the database

3). The majority of respondents were nurse teachers to these programmes.

Figure 5.6 identifies the specific questions related to Survey 3.

Figure: 5.6 Questions for Survey Three

Specific questions were framed around the following categories:

- Profile of participants
- Perceptions/agreement of definition of IPE/shared learning/attributes
- Profile of group(s) composition sharing learning milieu
- Academic levels
- Group size
- Shared learning in professional practice placements
- Role of teachers in professional practice
- Preparation of teachers and students
- Own preparation for role
- Ability to deal with teaching and learning situations/particular teaching approaches
- Ways to encourage collaboration
- Open comments

5.4.1 Results of Survey Three

This data was extracted from the questionnaire (Appendix 6) and analysed using either Access or Excel database as appropriate to compare variables.

The teachers in the survey held varied positions, from lecturers to professors and departmental heads, and worked within various faculties within higher education. The quantitative data was analysed to give a profile of the teacher's professional background (Table 5.18). A large percentage (62%) of the participants were represented nursing and health visiting teachers, while the remaining 38% were mostly from various health and social care professions. Some teachers were outside of health and social care but affiliated to IPE programmes. The reason for such a large representation of nursing and midwifery teachers is defensible in that the profession have taken a leading role in joint programming and the majority of the workforce comprises nurses, therefore student numbers are higher than other professional groups on average.

Table: 5.18 Profile of the Participant's in Survey

Profession	No. of Participants	Type of Profession	No. of Participants
Dentistry	2	Psychiatry Psychology	6
Nursing/Health Visiting (Adult=62, Child=9, Mental health=23, Learning difficulties=8,Community=51)	153	Radiography	7
Midwifery	12	Social Work/Sociology	10
Medicine	10	Pharmacology	2
Occupational Therapy	11	Physiotherapy	16
Podiatry	5	Speech Therapy	2
Others The category included: Biochemist (1) Biologist (1) Physiologist(1) Dietician (1) Family therapist (1) Health Educator (2) Lawyer (2) Researcher (1) Unidentified (2) (from community sciences and health and social care faculties)	12		
Total			**246**

Table: 5.19 Percentage of Teachers by Frequency of IPE Groups

Number of Groups	No of Questionnaires
1	184 (75%)
2	15 (6%)
3	7
4	2
5	1
6	0
7	1

5.4.2 The Composition of IPE Group (s) in Higher Education

There are a number of questions that were investigated in relation to the groups or cohorts of mixed professions. The data is presented in numerical order to address these questions.

1. Number of Groups Teachers Facilitated

Table 5.19 shows that the majority of teachers (75%) facilitated one interprofessional group only, and in a classroom-learning environment. Only 15 respondents (6%) facilitated two IPE groups. One participant facilitated seven groups.

2. Group Combinations

'How many combinations of mixed professional groups occurred?' The initial data analysis showed that the total number of professional group combinations was 255. This result included duplication of occurrences. This means that the same combination of professionals could have occurred more than once. The data was analysed further to identify unique or distinct records of group combinations. Excel database was used to filter the data to identify unique group combinations (n=177). These combinations showed the number of professions who formed IPE groups and how frequently these groups occurred.

Table 5.20 (page 147), shows that IPE groups comprised five different professions more often than any other combination. There were ten groups of individual professions (uniprofessional education) which were the professions identified in the questionnaire, with the exception of dentistry, health visiting and social

work/sociology. This means that the latter were always combined with other profession (s).

'Which professions were associated with each other to form unique interprofessional groups?' Table 5.21 (page147), shows the unique or distinct professional associations. The non-shaded area shows the total number of occurrences for that particular profession. The results show that radiography was less frequently combined in shared learning than all other professions. Nursing ranked highest in sharing with all professions, except with podiatry, when occupational therapy was equivalent in occurrences.

'Were there other people involved in group compositions?' The other (s) category (Table 5.22) shows other professions not identified on the matrix grid along with non-professional groups including the voluntary sector. This data is meant to exemplify the other people involved in shared learning and is not organised to prioritise any one group over another. These non professionals shared learning milieu with all of the professions except radiographers.

'Which teaching professions were facilitating different group compositions?' Analysis showed (Table 5.23) that nine teachers facilitated more than one group composition, with seven of these facilitating two groups. Only two teachers (physiotherapy and medicine) facilitated more than two groups while a medical teacher facilitated six. The number of professions in IPE groups ranged between 1-10.

Table: 5.20: Frequency of Occurrence of Professions by Number of Professions in Group

No. of professions in groups	Frequency of occurrences	Representation of profession	Dentistry	Health Visiting	Nursing	Midwifery	Medicine	Occupational Therapy	Pharmacy	Physiotherapy	Podiatry	Psychiatry	Radiography	Sociology\ Social work	Other
1	10		0	0	1	1	1	1	1	1	1	1	1	0	1
2	18		0	2	8	5	4	4	0	3	2	3	0	2	3
3	18		0	5	15	6	4	7	0	7	1	1	0	3	5
4	18		2	7	16	8	3	10	0	7	2	3	1	5	8
5	26		0	19	26	14	7	14	1	12	6	11	1	10	9
6	11		2	10	11	10	3	8	0	4	2	3	0	7	6
7	10		3	9	9	7	4	8	3	7	3	6	0	4	7
8	5		1	5	5	5	1	5	2	4	3	3	0	2	4
9	0		0	0	0	0	0	0	0	0	0	0	0	0	0
10	1		1	0	1	1	1	1	1	1	0	1	0	1	1

Table: 5.21: Frequency of Professions Associated with other Professions in IPE

	Dentistry	Health Visiting	Nursing	Midwifery	Medicine	Occup Therapy	Pharmacy	Physiotherapy	Podiatry	Psychiatry	Radiography	Sociology Social work	Other
Dentistry	9	5	7	7	5	6	3	6	2	2	0	2	5
Health Visiting	5	57	56	38	14	31	5	23	11	20	0	23	22
Nursing	7	56	92	51	21	49	6	38	15	28	2	33	37
Midwifery	7	38	51	57	13	29	5	24	11	16	0	16	23
Medicine	5	14	21	13	28	9	2	8	0	10	0	9	13
Occup Therapy	6	31	49	29	9	58	5	30	15	16	2	20	24
Pharmacy	3	5	6	5	2	5	8	5	2	6	0	1	5
Physiotherapy	6	23	38	24	8	30	5	46	12	13	2	9	15
Podiatry	2	11	15	11	0	15	2	12	20	4	0	4	7
Psychiatry	2	20	28	16	10	16	6	13	4	32	1	10	13
Radiography	0	0	2	0	0	2	0	2	0	1	3	0	0
Sociology Social work	2	23	33	16	9	20	1	9	4	10	0	34	18
Other	5	22	37	23	13	24	5	15	7	13	0	18	44

Table: 5.22: Other(s) Identified in IPE Group Compositions

Dieticians	voluntary staff special services
Speech and language therapists	voluntary sector, mental health, community priests, chaplains
Osteopaths	lay people, patient representatives
Physics, medical physics	youth workers
Chemistry	
Echocardiographers	Health and Social Service Managers
Health promoters	Professional
Public health	Care/ service users
Environmental health graphics	Leisure
Environmentalist	County council
Teachers(occupational therapy, speech and language special needs)	Audit facilitators
	Administrative staff
Dental technicians:	Ambulance personnel
Cardiac technicians	Access (S.W.A.P)
NVQ's technicians	Paramedics
Drama students	prison officers
Architects /designers	Ancillary staff
	funeral parlour workers
	and various caring backgrounds

Table: 5.23: Teachers who facilitated more than one IPE group

Teacher	No. Of Professions in Group(s)	No. Of groups
Nursing	3 & 4	2
Nursing	3 & 5	2
Nursing	3 & 3	2
Midwifery	3 & 3	2
Midwifery	2 & 2	2
Medicine	3 & 5	2
SocialWork	1 & 5	6
Medicine	1 & 2 & 2 &2 &3 & 10	3
Physiotherapy	2 & 3 & 3	2
Total=9		**23**

3. Group Size

The data was analysed to identify how many teachers were facilitating different sized groups. Not all participants answered this question (86.5%). The size of groups for shared learning environments shown in Table 5.24 shows that teachers 31% (n=66) commonly facilitated smaller groups which would accommodate IPE. However, the results also showed that 23% of participants (n=50) facilitated varied group sizes.

Table 5.25 indicates the number of responses on group size in relation to their own professional background. Teachers in nursing facilitated all group sizes with the exception of the largest category (91-100). The high representation of nurse teachers in the survey may account for this.

As group size increased, a pattern emerged which showed that the teachers from nursing, along with occupational therapy, radiography or physiotherapy, were more common. This could suggest that these teachers were more likely to collaborate in IPE at the time of the study. However, the picture portrayed that group combinations showed radiography as least likely to form part of IPE. The results cannot suggest that the frequency of these group sizes relate to the combination of groups respectively. It was therefore inappropriate to analyse the data to compare both variables, group size and group combinations.

Table: 5.24 Number of Teachers in Comparison to Group Size

Size of Group	No. of Teacher Responses
5-10	17
11-20	66
21-30	32
31-40	7
41-50	6
51-60	4
61-70	4
71-80	9
81-90	2
91-100	0
100+	7
Varied	50
Not applicable	*9*
TOTAL	**204 =(83%)**

Table: 5.25 Comparison of Teachers' Profession to group size in IPE

Size of Group	Nursing	Midwifery	Medicine	Occupational therapy	Pharmacology	Physiotherapy	Podiatry	Psychiatry\Psychology	Radiography	Sociology\social work	Other	Total response
5-10	8		3	1			1	1		1	3 (family therapy speech therapy/ unknown)	17
11-20	43	3	3			3		1	1	4	7 (dietetics, speech therapy researcher health ed. Physiology, law-2)	66
21-30	19	4			1	1		2	1	3	1 (unknown)	32
31-40	4	1				1	1					7
41-50	4			1					1			6
51-60	2			1					1			4
61-70	2			1		1						4
71-80	2			4		3						9
81-90	2											2
91-100												0
100	6						1					7
Varied	28	2	3	3		3	2	2	3	1	3 (biologist, biochemist, health ed.)	50
Total	**120**	**10**	**9**	**11**	**1**	**12**	**5**	**6**	**7**	**9**	**14**	**204 (83%)**

4. Academic Levels

Participants were asked to identify the academic level of groups. Eighty eight percent of the sample answered. One hundred and one (47%) teachers were teaching groups at undergraduate level. Forty four (20%) taught at postgraduate level and seventy-one (33%) at both graduate and postgraduate level.

5.4.3 Shared Learning in Professional Practice

Over half of the sample of teachers (55%) stated that students did not undertake shared learning in practice placements. Slightly over half of the teachers (51%) indicated that they did have a role in teaching students in practice placements, while 49% did not. The number of teachers who had a practice role is identified in Table 5.26 in relation to their representation in the survey.

5.4.4 Preparation of Staff and Students

Teachers (72%) were of the opinion (see Table 5.27) that they required specific preparation for their role in shared learning environments, while 76% of them had no preparation for the role. Those who felt they were prepared for their role indicated that the preparation was limited with an average score of 2.13 on a 10 point scale (where 0=not prepared and 10=fully prepared).

Specific Teacher Preparation

'Did the teachers undertake specific types of preparation for teaching in shared learning environments?' Table 5.28 outlines the percentage of teachers who undertook different types of preparation for teaching in shared learning environments. Although the majority of teachers had identified a preference to have preparation for their role in shared learning environments, few (9%) had

Table: 5.26:

No. of Teachers with a Role in Practice Compared to Survey Sample

Teachers	No. in survey	No. in Practice
Family Therapy	1	1
Medicine	10	5
Midwifery	12	8
Nursing	153	79
Occupational Therapy	11	5
Physiotherapy	16	9
Podiatry/Podiatry & Radiography	5	4
Psychiatry/ Psychology/ Psychotherapy	6	3
Radiography	7	5
Social Work/Policy	10	4
Speech & Language Therapist	2	2
Others	13	0
Total	**246 (100%)**	**125 (51%)**

Table 5.27: Teachers' Views on Role Preparation

Need for Specific preparation	Prepared for Role
Yes= 178 (72%)	58 (24%)
No 68(28%)	188(76%)
Total 246	**246**

Table: 5.28: Percentage of Teachers who undertook Types of Preparation

Type of Preparation	Yes	No
Undertook a specifically planned programme	22(9%)	224 (91%)
Observed different teaching styles	36 (15%)	210 (85%)
Worked alongside an experienced teacher	20 (8%)	226 (92%)
Was allocated a mentor	10 (4%)	236 (96%)
Please add other(s) if applicable	25 (10%)	221 (90%)

undertaken any specific programme. Mentorship was rare, nor did teachers work alongside an experienced teacher. Some (10%) stated other types of preparation which is included in the qualitative data analysis in the next chapter.

Student Preparation

Teachers were asked if they prepared their students for their role in shared learning environments. Only 43% of teachers did, while 57% did not prepare them at all. The level of preparation for students gave an average score of 2.8 on a 10 point scale, which showed that the teachers felt that the students were not fully prepared for their role.

5.4.5 Teachers' Skills in Shared learning

The majority of teachers rated highly (Table 5.29) their ability to develop curriculum and teaching strategies for shared learning, and to assess and evaluate learning. In addition they felt able to deal with the classroom context. Although teachers had no specific preparation, the majority evaluated their ability to deal with these situations quite well. This may be because of experience of IPE or of other teaching and learning environments. Less than half of teachers (42%) used particular approaches in their teaching within shared learning contexts, while 35% did not. The average score of the teachers was 7.13 (SD = 2.6) on a scale of 10, indicating that they were generally more in favour than not in favour of shared learning. There were several comments in relation to this question, which are analysed in Chapter 6.

5.4.6 Defining Interprofessional Education

The majority of teachers (82%) agreed (Table 5.30) with the stated definition of IPE. Teachers who disagreed with the definition gave their reasons which are analysed in Chapter 6.

Table: 5.29: Teachers' Rating of Ability to deal with Situations in Shared Learning Environments

Statement	Very well	Quite well	Uncertain	Poorly	Not at all	Did not answer	Total
Developing curriculum frameworks	19%	41%	15%	6%	2%	17%	100%
Developing teaching strategies	20%	50%	9%	4%	1%	17%	100%
Motivating mixed groups	23%	42%	14%	3%	0%	17%	100%
Meeting needs of minority professional groups in the classroom	9%	36%	30%	7%	0%	18%	100%
Providing relevant examples for learners in relation to their professions/disciplines	9%	48%	18%	6%	1%	17%	100%
Breaking down professional barriers	19%	43%	18%	3%	0%	17%	100%
Encouraging collaboration in learning	22%	46%	13%	2%	0%	17%	100%
Encouraging learners' self-appraisal of shared learning	12%	38%	26%	6%	2%	17%	100%
Assessing peer group learning	9%	37%	26%	9%	2%	17%	100%
Evaluating the effectiveness of shared learning contexts	9%	39%	23%	8%	4%	17%	100%

Table: 5.30: Teachers Level of Agreement with IPE Definition

Yes	No	Don't Know	No response
203 (82.5%)	28 (11.4%)	11 (4.4%)	4 (1.6%)

Table: 5.31: Teachers Level of Agreement with Attributes of Shared Learning

SHARED LEARNING:	SA	A	U	D	SD	Total
Promotes mutual understanding of roles	108 (47%)	100 (44%)	11 (5%)	9 (4%)	1 (0%)	100%
Disadvantages minority groups	12 (5%)	47 (21%)	67 (29%)	82 (36)	20 (9%)	100%
Promotes creative teaching	57 (25%)	102 (45%)	45 (20%)	19 (8%)	4 (2%)	100%
Helps breakdown professional barriers	87 (38%)	106 (46%)	21 (9%)	9 (4%)	6 (3%)	100%
Limits teaching to principles of the topic only	17 (7%)	71 (31%)	34 (15%)	78 (34%)	29 (13%)	100%
Enriches the learning process	80 (35%)	102 (45%)	34 (15%)	8 (4%)	3 (1%)	100%
Increases cost effectiveness	41(18%)	73 (32%)	77 (34%)	30 (13%)	7 (3%)	100%
Can provoke anxiety in students	23 (10%)	103 (45%)	53 (23%)	47 (21%)	3 (1%)	100%
Enhances personal development	51(23%)	115 (51%)	43 (19%)	10 (4%)	6 (3%)	100%
Dilutes specialist subject matter	32 (14%)	53 (23%)	49 (22%)	79 (35%)	14 (6%)	100%
Encourages self-appraisal	31 (14%)	93 (41%)	68 (30%)	32 (14%)	5 (2%)	100%
Causes problems in planning programmes	46 (20%)	86 (38%)	36 (16%)	52 (23%)	9 (4%)	100%
Promotes collaborative teaching	67 (30%)	110 (48%)	32 (14%)	14 (6%)	4 (2%)	100%
Requires specific preparation for teaching	69 (30%)	111 (49%)	19 (8%)	26 (11%)	3 (1%)	100%
Creates interdisciplinary rivalry	7 (3%)	27 (12%)	52 (23%)	110 (48%)	32 (14%)	100%
Is a cost cutting exercise	18 (8%)	41 (18%)	58 (26%)	59 (26%)	49 (22%)	100%

SA = Strongly Agree, A = Agree, U = Uncertain, D = Disagree, SD = Strongly Disagree

5.4.7 Teachers' Views of Attributes of Shared Learning

The frequencies of scores for the attributes (Table 5.31) were similar to those of the new teachers in nursing and midwifery with three exceptions. Although the spread of scores on the statement regarding cost effectiveness were towards agreement with the statement, there were slightly more teachers of health and social care who were uncertain (34%) than in agreement (32%). Nurse and midwifery teachers (47%) agreed with the statement. Scores for the statement 'can provoke anxiety in students' were also different. Where a majority (41%) of nurse and midwifery teachers disagreed, the results of the broader survey showed 45% in agreement. Teachers in health and social care were generally in agreement (38%) that shared learning cause problems in planning programmes, whereas nurse and midwifery teachers (31%) disagreed. The assumption from these results is that personal experience and exposure to discussion on shared learning could influence these scores.

The scores for teachers of health and social care were analysed using Spearman's correlation to look for associations and significance. The statistical significance between statements was collated at p=0.01 level and p=0.05 level (two-tailed). The results identified an inverse relationship between positive correlations and negative correlations. The statements with the greatest number of non-significant correlations were; increases cost effectiveness, can provoke anxiety in students, encourages self-appraisal, and requires specific preparation. A similar pattern emerged when the scores for both surveys were combined, with one exception, where *encourages self-appraisal* was significantly associated to most other

statements. The results of frequency scores showed that the teachers were more in agreement than disagreement with the statements.

5.4.8 Summary of Survey Three

This survey aimed to identify the perceptions of teachers involved in IPE programmes listed in the CAIPE Database. This resulted in a sample of teachers where nurses, midwives and health were a majority because the sample reflected the programmes as opposed to the organisations delivering the programmes.

Most of the teachers (75%) were involved with one IPE group with a minority facilitating more than one. There were nine teachers who identified their involvement with more than one group. A teacher of medicine was exceptional in facilitating a group of ten professions and also in that they facilitated more groups than all other teachers. The group size or student cohort was mostly between eleven and twenty professionals. However, half of the respondents were facilitating varied group sizes, which ranged from five students to more than one hundred.

The group combinations were more representative of nurses sharing with other professions. Dentistry, health visiting and social work were always combined with other professions. Non professional representatives were frequently involved in learning with nurses, midwives, occupational therapists and health visitors.

Most of the teachers (47%) taught at undergraduate level while some (33%) taught at both undergraduate and postgraduate levels. Over half of the teachers

were involved in some capacity in professional practice. Yet, most of the students were not sharing learning in practice environments.

The majority view was that teachers required preparation for their role in shared learning milieu, yet most had no preparation. Only 9% had any planned programme with 10% who had other specific preparation. Less than half of the teachers prepared students for shared learning milieu, and those who indicated that the students were prepared suggested that this was below average. Teachers were confident in their ability to deal with shared learning in the categories identified. However, less than half used any particular teaching approaches.

Most teachers (82%) were in agreement with the operational definition of IPE. Some teachers (28%) gave reasons for disagreement while others were unsure. The teachers' level of agreement with the attributes of shared learning showed a spread of scores, which are similar to those, identified by the teachers of nursing and midwifery in Survey 2.

5.5 Comparison of Quantitative Findings

The analysis of data identified that student teachers were exposed to shared learning in their teacher education. The majority of them shared learning with others from the various branches of nursing and midwifery, while some shared with a range of other professionals who were independent of health and social care. On completion of their teacher education, new teachers were teaching in shared learning environments, although, the student cohorts were mostly from nursing and midwifery backgrounds. Teachers of health and social care

professions were dealing with variable combinations of professions in their groups along with representation from non professions. Their teaching included undergraduate and postgraduate academic levels and the size of cohorts were variable. Teachers from nursing, along with occupational therapy, radiography and physiotherapy, were more likely to teach larger groups.

The majority of course leaders in teacher education centres indicated that shared learning was promoted in their institution, although the degree to which this happened varied. The ideology of shared learning environments was biased towards using resources efficiently, although, the course leaders wanted to provide competent interdisciplinary teachers. In colleges of nursing and midwifery, shared learning was already happening and there were intentions to expand in this direction. In higher education, the teachers were facilitating programmes which were regarded as interprofessional education.

The programmes on offer had common curriculum components such as; the learning outcomes, assessments, and award systems. Learning together was confined to the theoretical aspects of programmes where peer learning was practised. Programmes which were described as interprofessional were equally classroom based where different professions were grouped together. The majority of teachers were involved in professional practice to some extent, but the students did not formally share learning in these environments. Evaluation of programmes was not tailored to identify the affects of shared learning or interprofessional education.

The data was examined to identify if the teachers were biased for or against shared learning. The mean scores showed that teachers to IPE programmes were in favour of shared learning environments but that the perceptions of student teachers and course leaders in teacher education were of opposing views regarding the staff (teachers) delivering teacher education programmes. They perceived that the staff were in favour of shared learning and that students were generally in favour of sharing with other disciplines.

The majority of course leaders were of the opinion that both staff and student teachers were prepared for their role in shared learning environments. Yet, collaboration between the institutions and other bodies focused less on preparation of staff than another other reason for collaboration. The new teachers in colleges of nursing and midwifery (60%) were of the opinion that teachers were not prepared for their role in shared learning, and 50% felt that students were not prepared either. The majority of teachers in health and social care (72%) were of the opinion that preparation was required, but 76% were not prepared.

Where preparation was given, the results showed that teacher education centres rated highest in how well teaching staff and students were prepared. A comparison of mean scores across all groups of participants suggested that new teachers rated the level of preparation for teaching staff and students lower than both other groups of participants.

On completion of teacher education, new teachers were teaching in shared learning environments. They frequently (60%) undertook an induction programme and most (57%) were mentored. There was less evidence of formal opportunities

to observe different teaching styles or work with experienced teachers. Likewise the majority of teachers (91%) had not undertaken a specific programme and over 70% had none of the preparation specified. The evidence leans towards the conclusion that preparation of staff or students for shared learning environments was inadequate.

In contrast to this argument, the new teachers felt well able to deal with teaching and learning strategies and curriculum development for shared learning, following their preparation programme. These teachers were less confident in dealing with minority members in groups. The teachers in health and social care equally portrayed their ability to deal with shared learning environments positively. This raises the question what preparation do they feel is necessary?

Teachers from both surveys evaluated the attributes of shared learning. Table 5.32 shows that the teachers were agreement with the positive statements on shared learning and in disagreement with the negative ones. These attributes have been structured in terms of five categories in Table 5.33.

The average scores show that teachers agreed that shared learning could promote mutual understanding and help breakdown professional barriers. Shared learning can promote creative and collaborative teaching which is not limited to teaching principles of the topic, or dilution of specialist knowledge. The participants agreed that the teachers require specific preparation. There was agreement that shared learning can be a means of personal development and a method of self-appraisal. The majority agreed that shared learning can enrich the learning process but may

provoke anxiety for students. Most of the participants viewed it as cost effective and not a cost cutting exercise but perceived that it causes problems in the planning of programmes.

As the data was asymmetrical, Spearman's correlation coefficient was used to examine the type or direction of relationship, which is, whether the relationship was positive or negative and the strength of the relationship between statements (Munro & Page 1993). The correlation estimated the r-value for the sample of 229 responses taken the df=200 and a table value of 0.138 as a level of significance for a two-tailed test.

The three interrelated assumptions included in the category profession *focused* relate to teachers' perceptions of the influence of shared learning on roles, professional barriers and rivalry. Retrospectively *interdisciplinary* rivalry would be replaced by *interprofessional* rivalry, although participants did not dispute the terminology or give responses to suggest misinterpretation. There was a significant negative correlation *(p=0.00)*, between this assumption and *promotes mutual understanding of roles* and the assumption *creates interdisciplinary rivalry.* In comparison, the data yielded a positive correlation *(p=0.00)*, between *promotes mutual understanding of roles* and *helps breakdown professional barriers.*

The statements within the category *role focused* showed significant positive associations ($p \geq 0.00$) between the first three statements. There was equally a strong association between the statements *limits teaching to principles only* and

dilutes subject matter. In contrast, there was an inverse relationship between the latter two statements and *promotes creative teaching* and *promotes collaborative teaching*. The category identified as *person focused* showed a positive correlation between the two statements *enhances personal development* and *encourages self-appraisal* where p=0.00 two-tailed significance.

The category *student focused* showed an inverse relationship *(p=0.00)* between *disadvantages minority groups* and *enriches the learning process*, with no significance between the latter and *can provoke anxiety in students*. The remaining category which was *management focused* showed a positive correlation *(p=0.02)* between *increases cost effectiveness* and *is a cost cutting exercise* with no significance between cost effectiveness and planning programmes, but a strong correlation *(p=0.00)* was computed between the latter and cost cutting.

The three less significant statements were; *increases cost effectiveness*, *can provoke anxiety in students* and *requires specific preparation*. This means there was no association between these statements and most others.

The results indicate that the teachers were consistent in their scoring which increases the reliability of the results. The statements offered in the survey need to be placed in the context of the type of teaching and learning perceived as shared learning and interprofessional education. The qualitative data gives a clearer picture and a direction towards an overall conclusion (See Chapter 6).

Table: 5.32: Combined Frequencies of Teachers' Scores on Attributes of Shared Learning

Statements	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Total
Promotes mutual understanding of roles	47%	44%	5%	3%	0%	100%
Disadvantages minority groups	6%	22%	27%	37%	9%	100%
Promotes creative teaching	27%	43%	18%	9%	3%	100%
Helps breakdown professional barriers	39%	47%	9%	4%	2%	100%
Limits teaching to principles of the topic only	7%	31%	14%	36%	12%	100%
Enriches the learning process	36%	46%	14%	4%	1%	100%
Increases cost effectiveness	19%	35%	33%	11%	2%	100%
Can provoke anxiety in students	9%	42%	22%	25%	2%	100%
Enhances personal development	24%	51%	17%	5%	2%	100%
Dilutes specialist subject matter	15%	26%	18%	34%	6%	100%
Encourages self-appraisal	15%	43%	27%	13%	2%	100%
Causes problems in planning programmes	18%	36%	18%	24%	3%	100%
Promotes collaborative teaching	28%	50%	14%	6%	2%	100%
Requires specific preparation for teaching	27%	45%	12%	14%	1%	100%
Creates interdisciplinary rivalry	2%	12%	21%	49%	16%	100%
Is a cost cutting exercise	11%	17%	27%	28%	18%	100%

Table: 5.33: Five Categories of Shared Learning Attributes

Profession focused	**Person focused**
Promotes mutual understanding of roles	Enhances personal development
Helps breakdown professional barriers	Encourages self-appraisal
Creates interdisciplinary rivalry	**Student focused**
Role focused	Enriches the learning process
Requires specific preparation for teaching	Disadvantages minority groups
Promotes creative teaching	Can provoke anxiety in students
Promotes collaborative teaching	**Management**
Limits teaching to principles of the topic only	Increases cost effectiveness
Dilutes specialist subject matter	Is a cost cutting exercise
	Causes problems in planning programmes

5.6 Summary of Chapter

Teacher education was formulated to accommodate multiprofessional education where student teachers from varied backgrounds could share learning environments and learn from and with peers. The absence of other health and social care professions in comparison to non-health and social care professions was apparent. Student teachers shared learning milieu with others, but the results indicate that interprofessional education for teachers of health and social care professions did not extent to their preparation as teachers. Teachers of nursing and midwifery were exposed to teaching uniprofessional groups from the varied branches of the discipline. Equally they taught in multiprofessional educational contexts. Interprofessional education planned specifically for health and social care professionals was less obvious. The programmes for the broader survey of teachers were known as interprofessional education on the CAIPE database. The results highlighted that groups were mostly nurses sharing with other health and social care professions and nonprofessional groups. Radiography was the least represented of the professions. The nature of education within these groups is clarified in Chapter 6.

Chapter 6

Qualitative Data Analysis

Introduction to Chapter

This chapter deals with the qualitative evidence from the participants in the study (see Figure 6.1). The data is analysed from the findings from interviews with course leaders, new teachers in nurse, health visiting and midwifery education, managers and mentors. In addition, the questionnaire to teachers of health and social care professions asked for opinions on various issues around shared learning and interprofessional education. The similarities in the findings from both uniprofessional and multiprofessional stances were strikingly obvious. The data is organised to identify specific participant groups where necessary. However, as the findings compliment each other this is sometimes avoided to prevent repetition. The chapter begins with a profile of shared learning in the context of organisations. The next section addresses the organisational and policy impact on teaching and learning through IPE. The values and beliefs of teachers and their perception of roles are defined. Models of teaching and learning used to implement IPE are discussed. A section to discuss how participants defined the construct of IPE and shared learning follows this. The chapter concludes with a summary.

The sources for this qualitative data analysis are identified in Figure 6.1:

Figure: 6.1: Sources for Qualitative Data

Participants	Number of Participants	Method of Collection
Course Leaders	5	Interviews
Teachers (nurses/midwives)	17	Telephone interviews
New Teachers (nurses/midwives)	58	Questionnaires
Mentors	8	Telephone interviews
Managers	4	Telephone interviews
Teachers (health & social care)	246	Questionnaires

6.1 Profile of Shared Learning in the Context of Teacher Education

This section gives an outline of the case study centres and discusses elements of collaboration and competition in teacher education. The curriculum context for student teachers of nursing and midwifery and health visiting is outlined.

6.1.1 Case Studies

The response from the survey of ENB approved Centres for teacher education was used to identify five case studies. All of the case studies were within the higher education sector. An outline of the position of these centres at the time of the study places teacher education for nurses, midwives and health visitors in context.

Centre One was a long established institution that had evolved in efficiency and effectiveness through quality assurance measures. The school was almost totally self-servicing and 'buying in' of specialists was a rarity rather than a norm. Teachers took part in programmes at different academic levels and had the opportunity to network and interact with colleagues from varied professional backgrounds. Collaboration between departments within the institution was evident where teachers from varied specialist backgrounds contributed to teacher preparation programmes. Others teachers had commitments right across the board. IPE was promoted in curriculum planning through using a strategic overview of teachers' skills and learning outcomes for students. An opportunity for shared learning environments was proactively recognised and student centred collaboration was promoted across a number of programmes. However, there was

cognisance of the reduction in student numbers and cost-effectiveness was considered in order to sustain programmes.

Centre Two focused on primary and secondary teacher education more than health and social care professional education. The centre was evolving to match market forces and proactively dealing with flexible modes of delivery and access to programmes. APEL systems were not fully developed at the time of this study but moves to create a network of educational units/modules were underway. The flexibility of education through full time, part time and a distance education route created vast numbers of students with a relatively small quota of core staff. The shared components gave a diverse student group from health and social care backgrounds and multiple disciplines within Further Education. Shared learning was promoted in how the curriculum was structured and delivered but it was not explicit in the marketing material.

In Centre Three shared learning happened mainly between nurses' and midwives and numbers were depleting due to over resourcing and closure of Colleges of Nursing and Midwifery. The programmes were evolving to modular format and the possibilities of students from more diverse backgrounds sharing in the future were evident. Student teachers could access postgraduate education, which was modularised to combine compulsory modules, education modules and option modules. This meant shared learning milieu between groups of health and social care professionals and others. Although the philosophy of the establishment valued shared learning, some health professional groups were viewed as *linear* in their professional beliefs and resisted change.

In *Centre Four* change had brought about an educational framework described as a matrix system. This allowed students to move along a chosen pathway and equally share with others from outside their own profession. Students could choose on-campus or distance education modules. Some resistance to distance education as a mode of delivery for shared learning was evident. A strong argument against distance education was the dilution of student contact time, group dynamics and group learning. A philosophy of IPE was evident in the Centre, a unit of learning called interprofessional studies had developed through collaboration between the schools of education and health studies. There was also a move towards all academics developing a teacher qualification. The interprofessional studies module was optional at the time. A specific focus within this module was conflict resolution. The intention was to expand interprofessional supervision, teaching and curriculum development.

Centre Five was below the normal quota of students and was feeling the effects of change within nurse and midwifery education. Students were from Further Education, Adult Education and Higher Education rather than health and social care backgrounds. This was due to the decline in demand for nurse/midwifery teachers. As a consequence, nurses and midwives were encouraged to form their own support group, additionally to team up with other professionals. A commitment to developments towards a shared learning forum was apparent. Staff collaborated across faculties in providing modules and there was a strategic move towards in-service development of staff towards teaching qualifications.

The data presented in the following sections stems from these case studies.

6.1.2 Collaboration and Competition in Teacher Education

This section and section 6.1.3 give an overview of the issues influencing teacher education in the centres chosen as case studies.

Collaboration and partnership with the statutory bodies is essential to validate and monitor nursing and midwifery teacher preparation programmes. In house collaboration was more evident than external collaboration. This was expressed as resulting from the political climate of the time, where competition forced establishments to look at productivity above creativity. One source of competition was the 'market'. Analysis of costs and funding of education played a huge part in how establishments looked at collaboration. Although peer review by other institutions happened, it was reducing to 'sitting on panels' as establishments protected their developments.

A second form of competition was the NVQ system. Some establishments saw that the only way to survive was *'to provide flexible low price products'* because of competition from others who were doing just that. The external environment in Colleges of Nursing was also in a similar predicament. These Colleges had to convince Trusts that their product was good and cost-effective. Consequently, increasing student numbers paid for and allowed re-developments to programmes.

Some areas were inundated with teachers in nurse and midwifery education. This was due to integration into higher education institutions and a decline in student numbers at pre- and post registration in the profession. There were therefore some

strong reasons for pragmatism and cost implications of having shared learning in modular programmes in addition to reasons based on educational ideology.

Flexibility was required to meet the needs of purchasers. It was also required in the programme structure and content. Traditionally new teachers left the programme and quickly gained employment in teaching, usually in Colleges of Nursing/Midwifery. Opportunities in the job market were changing and refocusing on teaching in professional practice. New teachers were taking up positions as lecturer practitioners or training officers or staff development officers and or working within Trusts.

6.1.3 Curriculum Context

APEL was seen as a bonus to teacher education. However, programmes differed in being either *content specific*, with a focus on professional education or particular to the process of *becoming a teacher*, and thus focusing on educational theory and practice.

Traditionally the statutory rules for preparation in teaching nurses, health visitors and midwives specified a professional education and a teacher education element. To satisfy these requirements nurses and midwives could make two main choices of programmes. They could either undertake a programme with a pure educational focus or choose a programme with a combined element of professional education and teacher education. Whatever the choice, student teachers focused on developing knowledge and skills in educational theory and applying this new knowledge in the practice of teaching their own discipline. As the profession is workplace oriented, practising teaching in this context is

inclusive of workplace and classroom achievements. Classroom practice placements were organised by the Centres. It was more usual for student teachers to arrange workplace practice placements themselves.

The teacher preparation programmes were designed within modular frameworks for undergraduate and postgraduate students. Pathways to obtain a teacher qualification varied depending on the centre and consequently the types of groups within shared learning environments were also varied. All five centres had nurses, midwives and health visitors on their programmes. In four of these centres these groups shared with other professions. Although nurses and midwives alone formed the group composition in one centre, both disciplines viewed themselves within different parameters from each other. There were other mixed professional groups within this centre. Therefore, the concept of shared learning was applied and described in a similar fashion to the remaining centres.

Shared learning environments were common through most academic levels in nurse, midwifery and health visiting education, mostly within post-qualification modules. Teachers were exposed to varied academic levels through their teacher education and in their teaching roles. In addition, the term *level* had a different connotation when referred to as different 'levels' of sharing learning in mixed ability groups.

Modularisation had become a powerful driving force for shared learning environments. The combined student numbers made larger classroom cohorts and could offer a range of studies and awards. A weakness of this framework was recognised in student teachers undertaking *a sea of modules* where group

cohesion was difficult to achieve. An extension to modularisation was the matrix system. This allowed greater flexibility of modules and easier access in different modes of study.

In general, the evaluation of Centres was positive as reflected in the following:

> *My own course was adequate, absolutely. I don't think any course can build in the reality factor. For the first six months after completion, I was constantly evaluating my practice and developing tools. Now that process has slowed down significantly although I do monitor my practice through evaluations* (nurse teacher).

Even when participants' perceived that shared learning was not explicit in their centre they had valued their experiences of sharing within a multi-disciplinary group:

> *It was not explicit but it seemed to work. I see a need for shared learning and as multi-disciplinary also. There is the issue of blurring identities, but nurses can have tunnel vision towards nursing studies only. I am also a psychologist/anthropologist. I have my doubts about courses that are purely nursing oriented, I would not have gone to certain centres because of this* (nurse teacher/psychologist).

Teacher preparation for nurses, midwives and health visitors was complicated by issues such as funding for preparation and the eminent integration into higher education. The latter brought about a new concern:

> *We are very committed to training teachers in continuing education. It is frankly very disturbing that only about 50% teachers in higher education are trained. I have a worry as nurse teacher trainers come into higher education they will start to regard themselves in the same way as other teachers in higher education not wanting to undertake teacher training programmes. The emphasis will be on the subject, training on masters degrees and Ph.D. which are obviously important; but the ENB's old commitment to training making sure that teachers are trained - will go by the board as they become more and more assimilated into the culture of HE institutions* (course leader).

The question of whether there is a need to prepare teachers for the new phenomenon of IPE was even more pertinent.

The following section explains the new teachers' perceptions of shared learning initiatives for nurse and midwifery education in the Colleges where they worked after their teacher preparation.

6.2 Profile of Shared Learning in the Context of Colleges

Teachers identified that their new positions as qualified teachers in nursing and midwifery programmes had evolved to a multiprofessional context or to a less evident, interprofessional context. Reference was made to a variety of teaching experiences in *shared learning* milieu. The range of experiences reflected the number of new teachers working with the Common Foundation Programme (CFP) of Project 2000 programmes for nurse education at pre-qualifying level. Other examples were selective modules where many professionals could access post-qualifying education. A few teachers were teaching within an interprofessional practice setting.

6.2.1 Pre-Qualifying Education

It was noted that the Project 2000 programmes created opportunity for shared learning to occur within the Common Foundation Programme (CFP), which consisted of eighteen months of shared classroom learning for all entrants to nursing. The benefits of sharing were challenged by the size of the groups. Despite the potential limitation of group size a very positive feature of this part of the study was the level of creative teaching demonstrated by this group of respondents and the efforts they were making, sometimes within difficult circumstances, amidst organisational changes, which created resource dilemmas.

The debate on whether it is fitting to introduce students to shared learning at a novice level was fashionable. Conflicts developed in shared learning environments for pre-registration students with limited experience to relate to. However, there were other reasons also why teachers' perceived difficulties at this level. This included a perception that the students did not readily see the relevance of sharing within mixed groups, and were influenced more by the traditional social image of nursing:

> *Post registration students come with a specific view in mind probably, the majority are self-motivated and have been in practice for a long time and have their own remit. Pre-registration students ask what has it got to do with us? It challenges the Florence Nightingale image and conflicts with their own beliefs. The social image is still very alive and influencing. They want to look at illness not health. Their expectations and what goes on is the cart before the horse in branch programmes* (nurse teacher).

Consequently, students entering the profession were at conflict with value systems from the onset. Changes have occurred recently to address the problems in P2000. The Commission for Nursing and Midwifery Education (UKCC 1999) recommended a change of policy to allow a greater time span for novice learners to become accustomed to their own special branch within the profession. This recommendation moves some ground in addressing the problems identified by the teachers in this study.

6.2.2 Post-Qualifying Education

Shared learning in classroom situations was prevalent in post-qualifying education and in-service training initiatives within service education provision. In some colleges, the post-qualifying framework for nurse education consisted of modules designed for multi-professional collaboration. This resulted in a trend to

deliver programmes as *core material* to large groups whereas the application of the subject matter was considered in smaller specialist groups. Core topics included health studies, professional studies, management studies, research methodology, and applied life sciences.

Some resistance to collaborative ventures between health and social care professions was noted. Scepticism stemmed from concern for dilution of disciplinary/professional knowledge and some felt it was a cost-cutting exercise. Others were more concerned with factors that could facilitate successful outcomes such as having appropriate skills to teach in a shared learning environment and developing an organisational culture to facilitate the same.

Interaction between teachers themselves was often difficult. The planning of shared learning within colleges varied from an ad hoc basis with teachers, largely, working independently on their specialist subjects, to some evidence of regular interprofessional interaction between teachers. Lack of interaction was sometimes due to the geographical location of professional education and, where structural integration occurred, sharing of knowledge and linking of subject matter was possible. However, some teachers found that they still experienced obstacles from colleagues:

> *I am generally in favour of shared learning but the only thing that I emphasise is that if you are doing shared learning all the tutorial staff doing the topic should meet before hand. Otherwise, you have people 'popping in' for seminar time and some of the tutorial staff could teach differently to what is expected. This could be a handicap to the students as well as the tutorial staff* (nurse teacher).

Commitment from the organisation in time and planning teacher deployment was also necessary:

> *One could say that any teacher has the skill to deliver in shared learning. It is not as simple as that. If teachers are working together on preparation of material and team teach, or teachers sit in on sessions this would take willingness on behalf of the organisation due to the time factor. The choice of teacher is important. A physiotherapy teacher might be the better choice to teach the musculoskeletal system for example. This could also help to bridge the theory-practice gap by giving the most relevant examples of practice* (nurse teacher).

Teachers who held managerial positions viewed part of their role as providing and deploying teachers to subject led modules and ensuring that the professional and academic expertise were available for the educational units. Foresight was necessary to identify potential opportunities to create shared learning between different disciplines. Curricular activities and resource planning including human resources had to be addressed. These managers found some resistance from professional groups as to the benefits of multiprofessional or interprofessional education over individual professional responsibility and autonomy in practice.

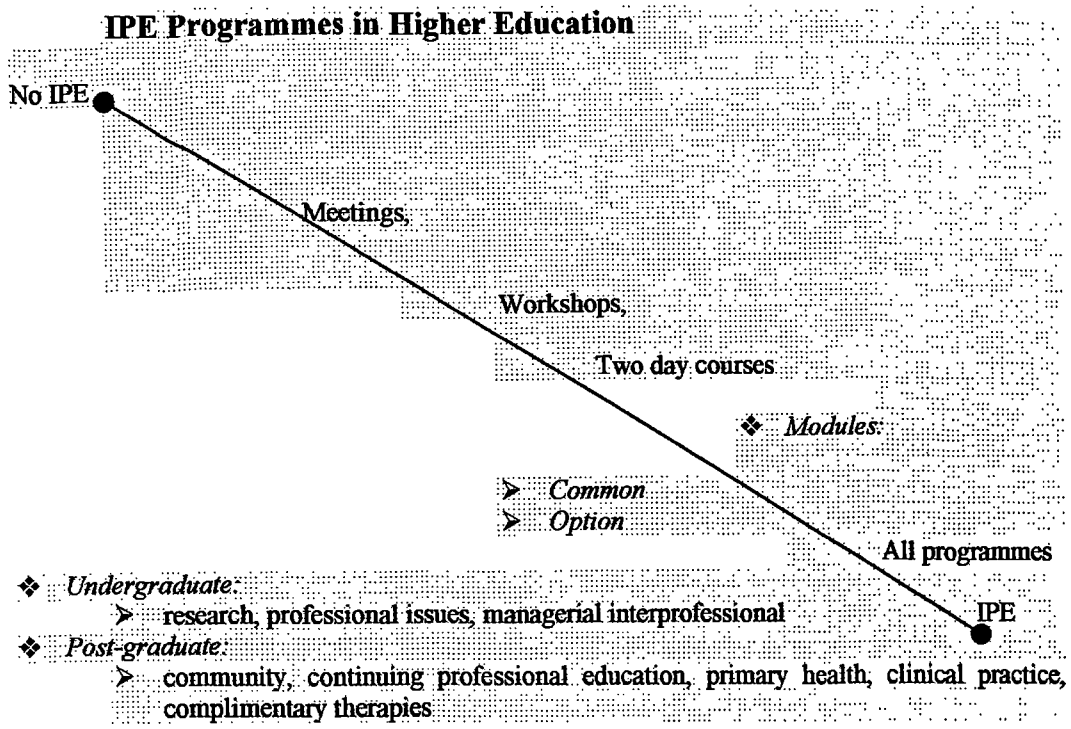
Interprofessional education in higher education is explained in the next section.

6.3. Profile of Shared Learning in the Context of Higher Education

Teachers from mixed professions in health and social care had various levels of experience in IPE environments. The data showed that faculties within universities were at various stages in developing IPE and shared learning within programmes. The range spread across a continuum (Figure 6.2) from specifically interprofessional to no initiatives of a shared nature between professionals. Most faculties were using core subjects as shared learning environments for health and

social care professionals. For some teachers the ethos of the university illustrated interprofessional collaboration across faculties and programmes.

Figure: 6.2 Continuum of IPE Initiatives in Higher Education



The following section addresses the organisational influences on IPE and implications for policy. The discussion draws on the data from all of the participants in the study.

6.4 Organisational Influences on Interprofessional Educational

This section begins with a discussion on the forces driving IPE and the beneficial outcomes of, and barriers to IPE are addressed. It concludes with a discussion on the policy implications for higher education.

6.4.1 Driving Forces

Participants were asked for their opinion on the driving forces behind shared learning. Opinions were varied between economical and educational forces with a tendency towards economical reasons (see Figure 6.3). This stance was clarified in how shared learning was implemented.

Figure: 6.3 Driving Forces for Shared Learning Environments

Economical	*Competitive market* *Pooling of resources* *Decrease in student numbers* *Quantity above quality* *Cost implications*
Educational	*Professional enthusiasm* *Facilitate sharing* *Improve client care*

Economical versus Educational Reasons

Huge changes had occurred with a competitive market and a decrease in student numbers. Managers were concerned about resources to facilitate educational developments. Although generally establishments showed enthusiasm towards shared learning a need to 'get the balance' right was expressed:

> *Instead of number crunching, we need to look for the educational opportunity first and foremost in sharing. Look for the quality rather than quantity* (occupational therapy teacher).

A practical way to remain viable in such a marketing world was to pool human resources. Efficiency in services meant that teachers were deployed to teach either across all academic levels using their specialist skills or teach selective groups using a generalist approach in problem solving. Fear of the consequences of IPE to professional identity was common:

> *When I think about the answers I have given you, I might have sounded very positive about shared learning and all of these integrated concepts. At the same time, I have some suspicion or disagreement with the underpinning forces that are producing shared learning and I think that they are predominantly economic. So what I might be saying is, that we as a profession, and me as a teacher need to keep my eye on what forces are producing shared learning. At the moment in my work role I feel quite in control of shared learning, but I would not want to generalise from my positive experience that shared learning was applied to all nursing groups or to all subject matters. I could see how nursing itself could be badly eroded by shared learning processes that were motivated by the need to economise. What might be eroded in nursing is the confidence and autonomy of the individual in the clinical area, in terms of the specialist skills and separate knowledge each individual needs. The word initiative sparked me off to thinking what forces are producing so much shared learning?* (nurse teacher).

Nurse teachers expressed fears about the merger into higher education institutions regarding the placement of nursing departments, resources, and the high potential of teaching large groups, and mixed professional groups.

There was a definite disagreement from the mentor responses that pooling resources were the primary reason for shared learning. Even if this was the case initially, mentors suggested that complementary developments had now outweighed any suggestions to the contrary. As health and social care is a multi-disciplinary phenomenon the potential and opportunities for shared learning across disciplines were now recognised. The philosophy of shared learning was acceptable provided it did not interfere with the quality of education subsequently it should be monitored sufficiently.

One of the themes that emerged from the data was that if professionals are joined together under the name of health professions, where education and the mode of delivery is by key lectures to one intake once a year, then it may be resource driven. Nevertheless, teachers have a role to play in identifying and justifying

what is needed. It was suggested that large groups are broken down into tutorial groups for key areas, although this would be a drain on resources, it could enrich learning. In contrast, the importance of content as a reason for shared learning was emphasised:

> *If the emphasis were on resources as a driving force, this would be a shame. Resources may lead the organisers to share learning environments but I would like to see the content take the lead to future developments* (course leader).

According to management, the fundamental reasons for shared learning are genuinely meant to facilitate sharing, for example it was noted that:

> *If we can get all professionals together in selective areas to work together and apply theory in practice by understanding roles, at best it will improve patient care and as a minimal outcome prevent duplication* (manager).

The potential for educators to work together to facilitate professional development to support care was recognised. Yet there was a perception that shared learning may be more theoretically useful long term than practically useful. The implications of flattening structures and breaking down barriers between professions might result in a return to teaching within separate specialisms.

> *People are more independent in their learning. The original research to suggest the importance of shared learning is no longer the emphasis as it has moved to another dimension. The actual process is more individual and focused into the individual's own needs within modular structures* (nurse teacher).

The participants gave particular benefits and barriers to shared learning and IPE. These are addressed next.

6.4.2 Beneficial Outcomes of, and Barriers to Shared Learning

The benefits (Figure 6.4) were perceived as strong reasons to engage in, and extend developments. The benefits of shared learning were seen as role related, group oriented, problem oriented and collaborative. These benefits highlighted some propositions. It was recognised that professional boundaries and tribalism could be resolved. Students could differentiate roles and build bridges between disciplines. Sharing could be extended to social activities. Traditional students in a separatist specialist programme were more compliant and accepting whereas students in a shared learning environment tend to challenge.

The main barriers or obstacles to shared learning (see Figure 6.5) were categorised as group oriented and programme oriented. The barriers suggest that shared learning was implemented without sufficient thought to planning of resources or the group composition required for the process. The process depended on teachers conciliating with groups in meeting individual and collective learning objectives.

Often the feedback from students was negative and they had a tendency to listen to the complaints from other groups rather than share learning. Teachers themselves had mixed feelings and some wanted to maintain the status quo of traditional approaches. Subsequently IPE would have no influence on the delivery of programmes. The barriers or obstacles were such that no easy solution emerged. The findings showed similarities to the benefits and barriers indicated in earlier studies reported in the literature (Jones 1992).

Figure: 6.4 Beneficial Outcomes of Shared Learning

• *Role related* • Breakdown professional barriers • Enhanced understanding of others' roles, problems • Greater understanding of similarities in roles • More flexible attitudes from students	*Group oriented* • Collegiality within learning group • Enhanced quality of input to groups • Mutual understanding within groups • Studying alongside students with different academic experiences • Students gain a broader perspective of health and social care provision • Social construction of understanding regarding teaching/education • Sharing with each other leading to more acceptance/respect • Sharing of ideas and learning outcomes • Quality of debate/discussion
• *Collaborative* • Ability to develop joint courses/units • Allows teacher to work with other students from different disciplines • Involvement of both students/teachers in the learning process • Involvement of students in the planning process • Involvement of students in the evaluation process • Joint professional development of teaching staff • Sharing good practice in promoting student learning	*Problem oriented* • More creative approach to problem-solving • Testing of general assumptions against different contexts

Figure: 6.5 Barriers to Shared Learning Environments

Group oriented
• Can provoke anxiety in students
• Self-esteem, students gauge themselves with those of higher academic ability
• Group composition, unequal representation of professions
• Interdisciplinary rivalries and stereotyping in groups
• Level of support needed can be very high
• Different expectations of teachers from different backgrounds
• Different level of involvement from each group
• Different levels of knowledge in group
Programme oriented
• Different outcomes for the programme students/teachers, a hidden curriculum
• Larger group size
• Lack of depth, teachers go for breadth to cover all groups needs
• Varying levels of commitment to student-centred teaching/learning
• Limited experience and knowledge of each professional activity
• Maintaining relevance, student led course work, clinically relevant scenarios
• Teaching "principles" difficult for students to grasp

6.4.3 Policy Implications for IPE

This section discusses the implementation of policy for IPE and the implications for higher education.

Teachers in health and social care identified several factors that inhibited smooth development of IPE within higher education. Many of these factors suggested a breakdown in collaboration at higher levels in policy formulation and implementation.

There was a deficit in the GP workforce at a time when major government policies were underway in primary care. The international change of emphasis on a health model has its virtues, but did little to rectify the immediate problems in GP practice. Diverse fiscal arrangements existed for students within different professions and the attitude towards self-funding varied. In addition, employers in Trusts were reluctant to release many professionals simultaneously from a workforce already below quota in some areas. Financial constraints hindered smooth functioning both inside and outside higher education. Professionals who were collaborating were often under the ethos of different faculties. Rooms were not equipped and/or insufficient in quantity to deliver the programmes.

Universities were seen as supportive towards IPE for a variety of reasons:

- *commitment of individual staff members to shared teaching and learning as important to professional development of undergraduates*
- *multi disciplinary practice teaching course*
- *economy of scale; broadening horizons of staff and students*
- *aims to incorporate all professions allied to medicine into their overall scheme for the future* (occupational therapy teacher).

Professional bodies were criticised by some teachers as reluctant to show willingness towards or leadership in IPE developments.

> *There is a lot of verbal encouragement but the professional bodies give an old fashioned approach, which causes constraints* (social work teacher).

Criticism of government policy was aimed directly towards IPE being used as a guise to *maximise learning opportunities*. This suspicion gave rise to what was seen as a hidden agenda of *moving professional boundaries* for fiscal gain rather than health gain. Trusts were being requested to offer joint training and development to professionals. The use of integrated care pathways for clients had helped shared learning. Contracting by Consortia led to conflict between educational philosophy and service philosophy.

Management was faced with some key issues in order to combine economical and educational philosophies (see Figure 6.6). The problems revolved around using teaching resources efficiently while experiencing resistance from some teachers to shared learning. One tool was to get teachers away from their traditional ways of thinking and teaching around their own specialist areas towards the broader concept health, thus supporting a generic model of teaching.

Figure: 6.6 Key Organisation and Management Issues

- Shared learning can be much more economical with teaching resources because different groups can learn together with one facilitator
- Students can get cross-fertilisation of ideas irrespective of their special interests
- Shared learning can maximise learning
- It is important to maintain quality of student experiences
- To create focused sharing is a better approach

The problem of using human resources efficiently and effectively to gain added value fiscally and educationally created a dichotomy in the learning environment. Using one teacher to meet multiprofessional needs while simultaneously, improving the quality of a learning experience led managers towards *focused sharing* as a solution. This idea is similar to the specific focused model (Gill & Ling 1995), where specific role functions are identified and several professions share the learning environment. With this approach, the content would have relevance to all concerned.

The targets for shared learning supported the view that what was happening in these environments was more like multidisciplinary education than interprofessional education. The economical reasons outweighed educational reasons. Some areas were exploring the possibilities of extending shared learning environments between health social care professionals. There were, however, reservations as to how barriers and 'status issues' between groups could be diluted and it was felt that it would be years before 'real shared learning' would materialise. This was further supported by the responses that at present, 'lip service' was given to shared learning, suggesting that the experience was more akin to sharing classrooms rather than shared learning.

> *If the top of the house is positive then there is greater shared learning. The true benefit of shared learning in a real professional sense is extremely overrated. I have taught mixed groups for years and feel that beyond the efficiency argument shared learning is merely a politically correct phenomena. It often reinforces professional stereotypes and our own evaluations show that most students cannot identify any concrete benefits of shared learning beyond feeling that 'it is a good thing to do' The outcomes for quality of care delivery following these initiatives remain as yet unproven. Moreover, there is a big price to pay in terms of loss of speciality knowledge and skills and an increase in role overlap, ambiguity and other negative outcomes linked to generic approaches* (nurse teacher).

The data supports the notion of pooling resources together for economical reasons more than interprofessional developments. Most of the programmes suggest core material for mixed groups rather than a focused initiative where the main purpose is interprofessional interaction. Core topics such as interprofessional skills, management, health and safety, moving and handling, marketing, research, facilitating learning and supervision of practice were regular classroom shared sessions.

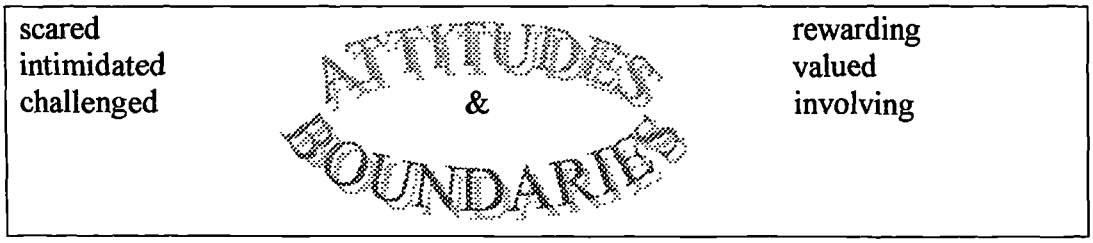
The next section discusses the teachers' attitudes towards IPE, how they viewed their role, how they were prepared for their role, and how they prepared the students for interprofessional education.

6.5 Teachers' Values and Beliefs

> *Attitudes of staff are a prerequisite to structuring a framework that makes shared learning possible* (occupational therapy teacher).

Positive attitudes towards IPE are a prerequisite to success, especially from teachers. The comments made by teachers showed emotive responses to their situation. Figure 6.7 shows, that these emotions polarised the good and bad of dealing with IPE. They were at worst intimidated, scared and challenged from a negative perspective, or positively felt rewarded, involved and valued the experience. Boundaries between professions were the root cause for such emotive responses. It was said, that s*tudents are better able to cope with IPE, as they have no power base, and, less institutional pressure* (podiatry teacher).

Figure: 6.7: Teachers' Values and Beliefs on IPE



Participants gave their opinion on how their own profession valued IPE. Nursing as a profession had become accustomed to shared learning environments of a uniprofessional nature:

> *Our profession is into shared learning but then nurse teachers have always been involved with shared learning, initially with the same discipline then it branched out, even before we joined the university* (nurse teacher).

While others saw repercussions:

> *Many people are scared of shared learning because if they expose their weakness to others in this setting it may be used against them* (nurse teacher).

Boundaries between professions were influenced by preparation time and personal experience:

> *Influencing factors can include tutor perceptions, boundary obstructions that can be very difficult to breakdown* (physiotherapy teacher).

> *Lecturers/teachers need more time to prepare. I find this kind of work 'rewarding' as I find out about other professions* (podiatry teacher).

> *I am a course co-ordinator for a family therapy foundation level training for 9 years. The course is open to all disciplines and feedback and evaluation has demonstrated that this is its main strength. The teachers on the course also come from a variety of disciplines. My own post qualifying training was also based on shared learning and I really valued this* (psychotherapy teacher).

Participants expressed strong agreement with the assumption that professions become entrenched in their own value systems. It was addressed as one of the major obstacles against development. The rapid changes in education for nurses and midwives had pre-empted many changes to come. The hierarchical nature of professions in health and social care gave ammunition to unrest between groups. There was suspicion as to why the changes were occurring and whether any one profession might dominate professional education in the future. For teachers the job market in higher education was also a concern.

6.5.1 Teachers' Perceptions of their Role in IPE

Most of the new teachers who participated in this study appeared extremely innovative and motivated to create good examples of shared learning for their student groups. Many had found the experiences of their teacher preparation programme to be of benefit in stimulating ideas as to how to manage shared learning in their own roles:

> *I reflect this (my own experience) in covering the whole range of strategies. On a given day as I usually teach in terms of a whole day or a half day. I look to build in a range of experiential, lecture, self directed learning and library research into the whole day* (nurse teacher).

Teachers were also able to draw on their own past experiences to enhance their teaching strategies. The following example shows how a teacher facilitated shared learning for client groups and transformed this learning in the classroom:

> *As a mental health nurse I would facilitate groups for clients from a variety of diagnostic groups. There is a great deal of variety in how people perform within the group for example, there might be someone who is hypomanic sitting not very far away from them there might be someone quite depressed and the group might be about anxiety management. So I think perhaps from my nursing experience I am equipped to manage the strong variations in students and use it in a positive way for each individual* (mental health teacher).

Frustration and conflict resulted in teacher disillusionment where role differentiation came to the fore:

> *The physiotherapy students are so different, enthusiastic and motivated. Despite much extra work trying to win over these students (unsuccessfully in relation to my evaluation which noted my ability to make critical appraisal and research methods interesting to all groups) I felt that some of their attitudes were in conflict with our own. This is very difficult for me as a physiotherapist to develop a focus relevant to diagnostic radiotherapy for example, they felt that they had little autonomy or patient contact! Our roles are so different. A very disillusioned lecturer who loves teaching and being a physiotherapist* (physiotherapy teacher).

With modular systems, teachers seemed more likely to teach their specialism across different academic levels. Some teachers were delivering core lectures to large groups and then splitting them into specialist groups, which were facilitated by the specialist teacher. In contrast to this model teachers joined as *team teachers* and collaborated in planning and implementing the session, module or programme. Personal development grew out of team teaching:

> *With the teaching situation joint teaching and learning works very well and there is a high level of commitment* (nurse teacher).

> *With IPE there is ability to use a wider pool of staff with unique specialist skills and develop personal teaching abilities in a wider and more challenging setting* (podiatry teacher).

Role change also meant that the *teacher became a facilitator of the educational process.* Approaching education from an interprofessional perspective demands strategies to break down professional barriers formed by traditional approaches to education. This group of teachers were actively seeking out and giving examples from other disciplines. Some sought information from specialists, or colleagues from other disciplines and from their own literature searching or experiences. One teacher specifically looked for cross disciplinary examples when marking assignments, for example, in relation to advocacy or controlled environments. For

the specialist teacher, giving examples did not appear to be problematic because they can draw on their experiences.

Professionalism was perceived as one of the major obstacles to shared learning. The opinions were polarised between two camps. Those who resisted joining forces and preferred a separate education pathway, against those who positively sold shared learning as a way of changing attitudes. Frequently medics were selected as the professional group with most resistance. At the macro level, the philosophy between social and health services created resistance.

> *It would be valuable to create multi disciplinary shared learning to include junior medical staff, local authority and staff field workers who are unqualified. However, this is political and there are major cultural barriers. I have worked in child protection capacity in the past with social workers that have a broader picture, and it is easy for professionals to polarise. The NHS reforms have created a management culture. In nursing, accountability is greater, this is less of a feature in local authorities therefore there are major cultural barriers* (health visitor teacher).

> *It is idealistic to want shared learning in some respects but to get it off the ground is much more difficult in practical terms. There is a lot of evidence of professional jealousy regarding professional boundaries and people do not want to give too much up should they be lost. This is how professions have developed in society and they do not want to loose their identity* (medical teacher).

Role identity highlighted discrepancy in power and status of gender in professionals sharing common goals:

> *Nurses and social workers are mostly women and worse paid and in lower grades than doctors and psychologists, mainly men but do similar tasks. Hierarchical attitudes are mirrored in the treatment of families* (family therapy teacher).

> *It seems to be female staff that are involved in this type of teaching here* (podiatry teacher).

The professional power of medicine within a hierarchy was evident where medical practitioners recognised that their role gave access to communication across all boundaries. This role required association with all professionals and voluntary and private sectors.

The issue of gender was combined with empathy towards other professions:

> *Mixed groups which include doctors and health visitors, and Community Psychiatric Nurses (CPNs). It was initially intimidating for each group. Doctors, because the new training is based on a non-pathology model, which is difficult for them. For CPNs and Health Visitors being open and honest was difficult at first. Female doctors handle this better than males who find the equality of groups more challenging* (social work teacher).

6.5.2 Teachers' Perceptions of their Role in Professional Practice

The quantitative data showed that 125 (51%) teachers identified a role in professional practice. Eighty four teachers were outside of the nursing profession, which was the largest single profession to respond.

These roles and functions are outline in Figure 6.8. Roles varied in the level of support given to students and the type of teaching in practice settings. What is significant about the data is the percentage of teachers from varied health and social care professions who had a practice role, yet most of IPE happened in classrooms.

Figure 6.8 Teachers' Role in Professional Practice

Role Identity	Role Functions
Practice teacher	Teaching students junior colleagues and peers Responsible for student cohort Tutorials Assessment (including non-professionals) Mentor support Facilitator Application of theory to practice
Link teacher	Working with mentors Monitoring practice placements- various professionals
Supervisor Family therapy supervisor Psychotherapy supervisor	Supervision of students Supervise reflective team work Role play and review video recordings Skills training Trainee supervision and teaching
Counsellor	Client counselling
Facilitator	Assist students set and produce evidence of learning outcomes Advise practice assessors Liason with clinical staff
Manager	Communicate with all personnel
Tutor	Teaching, supervision, assessment of community practice
Lecturer	Support community practice teachers and mixed professional student cohorts
Dual Role: Community practice teacher/Social work practice teacher Practice Lecturer	 Monitor, support, assess students Teaching functions

The teachers were equally faced with remaining abreast of change as professionals and teachers. Consequently, their role became threefold, teacher, professional and practitioner. This triangular nature of the teacher's role as a professional with specialist knowledge and skills to contribute to IPE is an invaluable resource. Ideally, each component of role functions should compliment the others. Under normal educational circumstances, it is difficult for a teacher to maintain competence in all areas. For IPE there is an additional demand on the teacher to remain abreast of developments from more than just a personal perspective. Some teachers were motivated and willing to meet these demands.

6.5.3 Preparation of Teachers and Students

This section identifies the preparation of teachers and students for IPE. The section begins with the views on what preparation is required for teaching in IPE. The teachers' perceptions of their own and students' preparation follows for this.

The question of whether teachers require specific preparation to teach in shared learning environments was addressed throughout the study. The Centres were reasonably confident that the programmes prepared teachers to teach IPE. Either the curriculum expressed an endeavour to provide opportunities for shared learning in meeting both generic and specific needs of teachers, or less commonly, an interprofessional focus was reflected throughout specific modules.

There was a consensus that the question of preparation required attention. The debate was grounded in the belief that general skills accrued through teacher education were sufficient or conversely, specific skills were required for this particular context. The data was examined using the assumption that specific preparation was required. Certain arguments emerged for and against specific preparation.

The strongest argument was whether the teachers should be prepared to use generic approaches to their teaching or function as a specialist in their own profession. The generic approach meant that teachers would not be required to modify their teaching to accommodate the various professions in IPE. The teachers using this approach taught the principles of the subject whereas the specialist teacher focused on the application of their specialist knowledge and

were more likely to accommodate the specialist needs of different professions. Another proposition was that if shared learning is *subject specific* then a specialist teacher is required.

Some establishments expected a highly specialised teacher and others looked for a generic teacher. It was easier for a sociologist for example, to work in a nursing department than vice versa. However, the application of specialist knowledge to nursing was also required. Some nurse teachers prepared themselves with dual professional qualifications as a compromise.

The specialist role could be recognised in how teachers were expected to organise their workload. The model of teaching hinging on the teacher as *subject specialist* or *expert* meant that teachers moved between different groups and at different academic levels to deliver their subject.

Delivery of IPE through core modules was criticised in its present form this emphasised resources as a driving force and because of the generic nature:

> *Yes (shared learning) is explicit in the institution within the higher award framework but it is generic. Some core modules are needed but not at the expense of specialism. Mental health nurses have suffered due to the change to a generic approach. Recent training courses are almost exclusively taught by non mental health nurses. Empowerment and advocacy suffer as a consequence* (mental health teacher).

The position was that new teachers faced a difficult position once qualified and course leaders had a challenging task in balancing both generic and specialist needs in preparing teachers. Certain solutions were proposed for and against this dichotomy.

A proposal that teachers should learn to be flexible and adapt to teaching different group composition was forwarded:

> *There really is no easy solution to how they should prepare themselves except to be flexible and be prepared to gain experience teaching groups they would not have otherwise consider they would wind up teaching* (course leader).

Applying this philosophy falls short of any measurable preparation and is totally dependent on the type of experience offered to student teachers. Another approach was suggested in that teacher preparation should aim to develop teachers' towards *transferability* of teaching skills across different group compositions. 'Thus once a teacher always a teacher'. But there was some doubt whether this was sufficient in shared learning milieu:

> *The knowledge and skills are transferable, but there is a need to look at strategies appropriate to the subject matter, as shared learning is probably more subject dependent* (course leader).

Some teachers felt it was essential to prepare teachers particularly for teaching in shared learning situations whereas others who were more experienced in teaching prior to their preparation course did not emphasise the need so much:

> *What is more important than shared learning and all the rest is teacher preparation. We must get the teaching right first and shared learning is miles away in the horizon as a concept* (pharmacology teacher).

> *Teachers definitely need preparation. As an expert in my field I don't have a problem as I am confident to teach all levels. Other colleagues might find shared learning threatening, if they are not sure of the group or not experienced in teaching. I will personally encourage shared learning in any environment, although it is not easy as others do not see its needs and it is difficult to facilitate this. Broader shared learning will depend on the Faculty in Higher Education we merge with. Lecturer practitioners can help to facilitate shared learning in practice placements* (nurse teacher).

Stronger opinions proposed specific preparation for the role:

> *Preparation is essential for the type of programmes they are expected to facilitate on return to their area of practice. Teachers need to be prepared for that broad perspective and be aware of the difficulties of actually bringing in those ideas to a group that have no nursing background* (course leader).

> *People assume they can do it without preparation which is unfounded* (manager).

Specific preparation of teachers for IPE was articulated as having distinctive elements. These were experiencing interprofessional education, the use of language for different professionals, diluting professional boundaries, developing group cohesion and a repertoire of teaching strategies. It was suggested that teachers require skills that are more *facilitative* than the more traditional approaches to education, and not only in the delivery of the sessions, but also in the follow up, such as; support and application to clinical practice for the student groups.

Distinct from this, a *personal experience* of shared learning environments was viewed as one way to gain preparation. This could be involvement in learning with other professionals in both formal and informal environments, supervision of students from disciplines other than one's own. The originality of the concept of IPE meant that most experienced teachers had no alternative but to use personal experiences and research findings to support the development of others. Enthusiasm and confidence in developing new teachers was obvious:

> *I would say with confidence that we achieve what we intend to achieve that graduates of ours will go out and be able to set up shared learning experiences for their students. We need to help our students to acquire it, if we do not they will not acquire it* (course leader).

A key to specific preparation for IPE was *the need to change one's language* to accommodate a mixed group of health and social care professionals and to avoid marginalisation of the less represented professionals. Then:

> *Everybody in the group has been treated as if their discipline has been addressed even though you yourself are not from the same discipline* (physiotherapy teacher).

One way of overcoming differences in how professionals interpret knowledge was:

> *The proper use of language in the classroom seems vital to me to ensure shared learning. Students cannot possibly share if all I do is lecture. I have to find ways of devolving responsibility for talk ...there is a high proportion of student group work, student projects, micro teaching and mutual evaluation* (course leader).

Of equal significance to the need for teachers to change their own language was *managing the students' language in the classroom.* Ways of accomplishing this included observation and participation in seminar work and shared reflection and analysis within interprofessional groups. Pitfalls encountered in giving examples to a mixed group of professionals were reported. Problems were firstly, in giving examples that were too generic, or skewed towards the teachers' own specialist knowledge and background, and secondly, dealing with different academic levels within student groups without placing the onus entirely on the group.

Teachers need to be aware that the same concepts are used differently in different disciplines, that is, not only does language differ but the theoretical paradigms differ also. Skills may manifest differently as well. This recommendation was conditional on all disciplines getting together to share ideas, look at strategies, topic areas, and the principles and skills considered as transferable. The quandary was not as simple as transferability or flexibility in teaching.

It was suggested that teachers learn to develop strategies on how to break down professional barriers and deal with professional values and beliefs. In reality this was not so easy as groups were often far too large, thus suggesting that shared learning was an economical commodity rather than a way to help people learn from each other.

Teachers required a repertoire of skills to facilitate mixed groups. The need for preparation for teaching in a shared learning milieu was summed up as:

> *Teachers can be prepared to enrich the learning process through mixed groups in their preparation centres. Teachers need preparation in how to handle these groups, to facilitate learning, and to use various strategies to achieve good results* (course leader).

It was expected of new teachers *not* to assume that everyone knows the concept of IPE. Hence the need to gain a better understanding of the roles of others, learn about planning and communication, be aware of peoples' different backgrounds, training, resources, and that different professions use resources differently. Also

> *The methodology needs to be reviewed. New teachers are weak on lecturing and running groups. There is a need for teacher training to address it* (course leader).

In antithesis to the notion of specific or special preparation was the view that some subjects have the potential to be badly taught whatever the approach, but that this could be exacerbated within a shared environment. One solution was to choose the most appropriately skilled teacher from *any* profession for the relevant subject matter. If such is the case, a model of teaching is suggested whereby the teacher moves between different groups to deliver their specialist subject.

6.5.4 Evidence of Teacher and Student Preparation

This section highlights the preparation of teachers and students in all of the establishments in this study.

The new teachers evaluated how the concept of shared learning was perceived within teacher education establishments and how the viewed their preparation. Figure 6.9 shows both sides of the coin. Those who evaluated positively gave a picture of commitment from the organisation and the teachers to develop a climate to accommodate sharing between mixed groups. The negative aspects are more synonymous with concurrent learning whereby groups were placed together for efficiency in resourcing education.

Figure: 6.9: New Teachers' Evaluation of Shared Learning within Teacher Preparation Centres

Positive Accounts	**Negative Accounts**
Commitment: Accepted as course philosophy Centre committed Encouraged by teachers All teaching staff ensured shared learning occurred almost all of the time	Uncommitted: Never discussed as a goal Ambivalent attitude from some module leaders Lack of library resources for specialist subjects
Curriculum: Broad access to programmes Reflected in planning and course content Extended outside the classroom Social context very much to the fore Facilitators encouraged cross-fertilisation of ideas Encouraged collaborative work Peer assessment, observation and feedback Common foundation were useful	Curriculum: uniprofessional shared learning, other health professionals on campus -not involved Took place as a by-product of course design Seemed a cost-cutting exercise Teachers relied on input from students Difficult to administer Problems in combining different academic levels Sitting in a classroom with other professionals is not synonymous with shared learning More specialist subject groups needed

Although the concept of shared learning was not always explicit, the teachers generally expressed positive feelings towards their own *personal development.* Those who experienced it had valued it, for example:

> *The course was for me about enrichment. The structure, style, management and student mix enabled this to happen* (nurse teacher).

Shared learning revealed a common aim between group members when exposed to cross-fertilisation of ideas:

> *Very informative and at times positively illuminating, we had more in common than that which divided us. It decreases insularity often apparent in nurses...Avoids tunnel vision and allows insight into others' views of your practice therefore challenging your values and assumptions* (nurse teacher).

Some teachers felt they had a good foundation for the role of lecturer practitioner and on return to their own areas had actively sought these positions or were forced to due to frustration and disillusionment with the quantity of classroom teaching.

No formal preparation of teachers or students for facilitating shared learning was evident in Colleges of Nursing and Midwifery. The philosophy of some colleges was such that different disciplines shared knowledge freely. Teachers informally shared ideas and worked towards making sessions broad and relevant to shared learning environments. Some respondents felt that the teacher preparation programmes would normally address this issue or that the teachers should be able to adapt their teaching approaches to accommodate different groups. One respondent suggested that as teachers were professionally qualified as nurses, midwives and health visitors, preparation was not necessary.

Some support mechanisms were visible from managers and mentors in these Colleges. Managers played their role by actively encouraging teachers to remain competent in their own specialism so that they are still in the ambience of clinical practice as *'you can soon loose touch with it if you are not in regular contact'*.

They saw the teachers' role in practice areas as a supporting mechanism for students and assessors, through familiarising them with the curriculum and assisting them to develop their competencies.

Sharing teaching was viewed as a way of maintaining professional standards and monitoring teaching approaches:

> *It goes back to (sort of) teachers twinning up, that is you can maintain your standards because the two of you will want to gain positive outcomes, because I'm not going to let the side down, almost. I think standards are increased by doing that* (manager).

Mentor systems to develop student teachers were in place in several colleges. Mentoring in this context included role modelling, sponsorship and coaching within an interactive relationship:

> *The person I am mentoring and I actually work in the same academic group, we both teach health. Therefore, we share views on how you would actually teach health and how you would facilitate it. There is that element. Another component is that we both share the same group of students and so we are actually looking at how we interact with these students in terms of counselling, in educational counselling, how we undertake those sort of duties as well. We discuss how we feel we can get the best out of students. We also look at things like marking, or facilitating, for her to go and work with somebody else because I feel that they have something to offer her* (mentor).

As mentors, experienced teachers viewed the role as a two-way process in working together. The relationship with the new teacher helped to facilitate professional development and development of teaching and learning strategies. Some interpersonal and management features were seen as important in interaction with the new teachers. Interpersonal issues were building confidence in classroom teaching, discussing student-teacher relationships, deflecting problems with personalities and role identity.

Common management problems were the management of time and planning of teaching sessions. Joint planning and delivery of sessions helped in professional development of new teachers along with monthly voluntary meetings or an open door policy. Mentors used strategies to facilitate shared learning such as: students' participation in their learning; students' reflection on their own areas of specialism; discussion groups; and giving examples in their teaching that referred to the different disciplines within a group.

Some students entering the programmes in these colleges were told they would be in a shared learning environment at interview and on course briefing days. One college provided a session to address training and assessment strategies, students' role and expected level of preparation. Others presumed that students could easily recognise the relevance of certain topics to their own specific specialist area.

In higher education, most teachers had no preparation and the preparation of students was minimal. Some teachers were of the opinion that inexperienced teachers need to learn the 'art of reflection' to teach IPE. Enthusiasm for IPE, and experience of shared learning, and teacher education were an obvious advantage in dealing with IPE. These traits were significant to individual preparation. Few teachers mentioned team preparation for the task and those who did felt the preparation was inadequate.

> *Before embarking on a shared learning programme the course team must develop a commitment to collaborate themselves. This ethos must be transmitted to multi -speciality groups doing curriculum development* (health visitor teacher).

Even joint preparation and planning for IPE ventures was not valued by some professionals who were conspicuous by shown resistance or absence.

> *The perceived value of one professional group education programmes to other professionals. Those who believe they know it and own it are unlikely to attend* (physiotherapy teacher).

> *It is interesting that in one interagency initiative (quality initiative and user-involvement) developed in a local provider unit the absence of one professional group (medicine) was notable. They refused to attend or acknowledge the project* (nurse teacher).

However, the resource issue created barriers

> *Staff teams often find it difficult to get to know others. It relies heavily on commitments from a few. Little time is given for preparing for teaching and developing strategies* (radiotherapy teacher).

Student preparation (see Figure 6.10) was considered and desirable but this was not consistent or premeditated for all programmes regarded as IPE.

Figure 6.10: Students' Preparation for IPE

➢ Student preparation is currently being explored in post -qualifying contexts. It is regarded now as essential but the means has still to be identified.
➢ New medical student have been given minimal preparation for the nursing perspective of their curriculum. This preparation involves both nurses and medical students.
➢ Nursing students are prepared for their shared learning experience, but medical students are not.
➢ I should hope that everybody would fully prepare students.
➢ Based on a visit to Maastricht and Linköping to study problem based learning approaches, student preparation is included to bring about interprofessional education.
➢ Postgraduates are prepared in the introductory module, which is compulsory.
➢ The use of shared learning within the institution for undergraduates is more difficult to arrange than for postgraduates. Timing is different partly due to practice placements.
➢ We have recognised that students need preparation for shared learning and will start this the next academic year for undergraduates. This preparation is unnecessary for postgraduates.

The next section discusses the models of teaching and learning used to implement IPE in all of the environments where the participants worked.

6.6 Models of Teaching and Learning

A comparative analysis of all qualitative data identified corresponding approaches to teaching and learning in environments for preparing teachers or students at different academic levels for IPE.

According to Joyce et al (1997), models of teaching can be categorised into four families based on the types of learning they promote and on their orientation towards people and how they learn. These families are the *information processing, social, personal and behavioural systems.* This categorisation will be applied to the models of teaching and learning described in this study.

The information -processing model helps the student to construct knowledge and increase their general intellectual and personal development. The purpose is to provide learning strategies for concept development relative to the disciplines. This model was more evident in *competitive learning*, which was especially when the student cohort were at different academic levels. Sometimes when sharing took place between groups it was a natural metamorphosis rather than a specific strategy initiated to explore this issue. In some instances, the value of the experience of sharing was not readily appreciated but had an impact through reflection later on.

Reflective learning took different guises and represents the personal family models of teaching as described by Joyce & Weil (1996). The emphasis is on self worth, personal confidence and competence. Reflection was used within teams to analyse a specific task or to analyse professional stances to a situation or problem. Teams took group exercises to link theory and practice and allow

reflection on the experience after the event. Reflection on practice took a student-led or student-centred approach in learning. Teachers acted as facilitators, a sounding board for reflection and catalysts for change. Role play and video were combined to analytically reflect on the process and allow peer and teacher feedback. The process of shared learning in itself was viewed as a personal reflection experience for the individual. Case studies were also used as a means for reflection on practice and professional roles.

Teachers had developed their own knowledge and skills in reflective processes through teacher preparation courses and had formulated a plan to utilise models of reflection and research as ways of breaking down barriers and as a developmental process at various levels.

> *When I started my course two years ago I had a very scant knowledge of reflective processes. We were presented with a range of models of reflection. I choose Benner's work and although it has its critics, it can get you into the habit of reflective writing and can be descriptive. Initially it can start the ball rolling and then you motivate people as they go through. The critical incident framework of Benner's I find exceptionally useful for a variety of reasons. For the 'reflective practice,' sessions on reflective journals something like a critical incident session, they have to bring a positive and negative incident for the basis of a small group discussion. We look at learning, development, both personal and professional as active processes* (mental health teacher).

> *Bringing teachers into that as well so that they can start to look at critical incidence and then later on, at the beginning of the branch we then raise the level and look at a different model such as Boud, Keogh and Walker. By the end of their training they will be familiar with at least two models (only going for 6 months yet). All of that knowledge and confidence I attribute to my course... Students and teachers are beginning to talk the same language and it seems to be working* (psychiatry teacher).

The aim of the social family models of teaching (Joyce et al 1997) is to develop co-operative action and mutual understanding. It took the form of *peer group learning and group interactive learning*. Peer group learning was valued by

teachers and seen as important that the group address and break down barriers to communication between professionals. Students were placed in small groups and given a task to deconstruct roles through case studies and feedback as a collaborative effort. Peers were seen as a tool for teaching, a means for appraising and reviewing learning between mixed groups.

Peer group learning was used to link theory and professional practice using past experiences of the group members. Common approaches to facilitate sharing within peer group learning were discussion and seminar work:

> *My teacher preparation course did not go into the mechanics of what/how to teach in certain groups but our own shared learning experiences were very valuable in learning the concepts and skills. Discussions and seminar work allowed me to develop teaching speaking skills* (nurse teacher).

Group learning was mostly teacher facilitated through assignments, problems for discussion, analytical reflection, constructive challenging, and group dynamics. The formation of groups was important in that teachers tried to develop equal representation of professionals and/or equal ability or background experience. The latter meant that the group composition did not lower confidence levels of the less experienced professionals. Teachers viewed their role as mentor or facilitator. Other ways of describing group interaction were *syndicate group learning and team learning*. As opposed to group learning, team learning was described as a way of team building. Teams were given projects with a team focus or role play and reflection to examine professional culture and conflict. Sometimes the interactive process took the shape of *paired learning* where students were matched in pairs to work on a task. Similarly in practice placements *shadowing and role modelling* were used.

Group learning seemed to happen serendipitously rather than as a distinctive characteristic and forced individuals to reassess their own thinking:

> *One of my colleagues in my immediate group was a radiographer and the rest were nurses. However, the shared learning environment was wider than nursing. We shared with all graduates for instance this could be, maths, history or drama. The group comprised a very wide variety of people and a lot of learning happened in these shared groups. I think what it taught me was the importance of accurate assessment. When colleagues talked about how they assessed I looked at these issues from my own perspective* (nurse teacher).

The behavioural systems family model of teaching aims to modify behaviour through role modelling, simulation and experiential learning strategies. There was ample evidence that student teachers in teacher education centres were exposed to *experiential learning* through role modelling and peer learning as preparation for their role. These approaches were equally highlighted as missing links for those who perceived their experience negatively. As teachers and peers role modelled the art of teaching, others could learn how to use examples.

Other teachers used experiential learning to allow interprofessional reflection and analysis of situations, events or problems. These activities were particular to encouraging collaboration and exploration of professional paradigms through small group activities. Students learning styles and Kolb's (1976) *Problem Solving Cycle* were fundamental commodities with which teachers planned progressive ways of reflection on experience.

Problem Based Learning (PBL) relates to the information processing family of teaching models where an inductive approach is used to identify problems and find solutions. Conversely, it could traverse or link with all of the models classified by Joyce at al (1997). This approach to teaching and learning in

education for health and social care professions has shown an increase over recent decades (Boud & Feletti 1991).

Teachers in this study valued PBL as a model of learning for mixed groups of professionals. The model allowed problems to become the core of teaching and learning. Student-centred learning with a focus on practical real life issues allowed teachers to explore and develop past experiences and attitudes and move groups into a new way of thinking. The ultimate aim in the process was to create in the student new and deeper approaches to the problem from different perspectives.

Strategies for facilitating PBL were formulated for analysis of practice through multiple approaches. These approaches were critical discussion, panel debates, case consultations, critical incident techniques, vignettes, videos, workshops and seminars. Professionals from different backgrounds role played their colleagues position as a professional. This helped to address professional identity and differences in feedback through reflection.

> *If problem-based learning in used as the messenger of interprofessional education, the biggest attribute is team-building* (midwifery teacher).

Undoubtedly, PBL was used as a tool towards team building, albeit classroom orientated, where the participants may not ever work together. Frequently the examples given by teachers of PBL were unidisciplinary. This meant that group learning was often *concurrent learning*:

> *By bringing them together in the same room at the same time, we assume they will collaborate. In reality, the occupational therapy and physiotherapy students sit apart from each other and have to be facilitated to form mixed grouped discussions. We explain the*

> *rationale for shared learning, but students tend to be largely preoccupied with their own specialism* (physiotherapy teacher).

Teachers identified many ways to encourage collaboration between professionals. The orientation period to learning within a mixed group was seen as essential to change or shape behaviour. The teachers using a *behaviour systems model of teaching* (Joyce & Weil 1996) at the beginning of the learning process to positively sell the idea of IPE. Promoting the innovation in itself was insufficient.

Teachers made efforts to breakdown conflict and stereotypical attitudes and raise the self-esteem of individual students. Positive reinforcement of the value of their individual and collective contributions paved a way for *collaborative learning*. Often obstacles through lack of organisational planning and professional willingness were in the way:

> *With difficulty even in seminars for year one they may come in with specific role identities and a 'keenness' to get on with study of their own profession. Any attempt to encourage cross-discipline discussion, or even just discussion with no professional boundaries, is difficult* (physiotherapy teacher).

> *This is difficult, as many times we do not know our target audience until introductions are done. So it is adapting to the students as they arise. Use getting to know you strategies and if forewarned we send out relevant written information to prepare participants* (nurse teacher).

Situations in which teachers endeavour to ensure students play an active role in their learning can be categorised as *participatory or active learning*. The most frequent approach to involving students was to take from their experiences and develop discussion relevant to practice within different areas. Other approaches were used to help the student group participate in a shared learning environment. These included using film clips and autobiography (client stories). There was an added advantage to using such approaches:

> *This creates a better use of language as the concepts used tend to be from the educational domain. Through reflection on practice, one can utilise examples from students also* (nurse teacher).

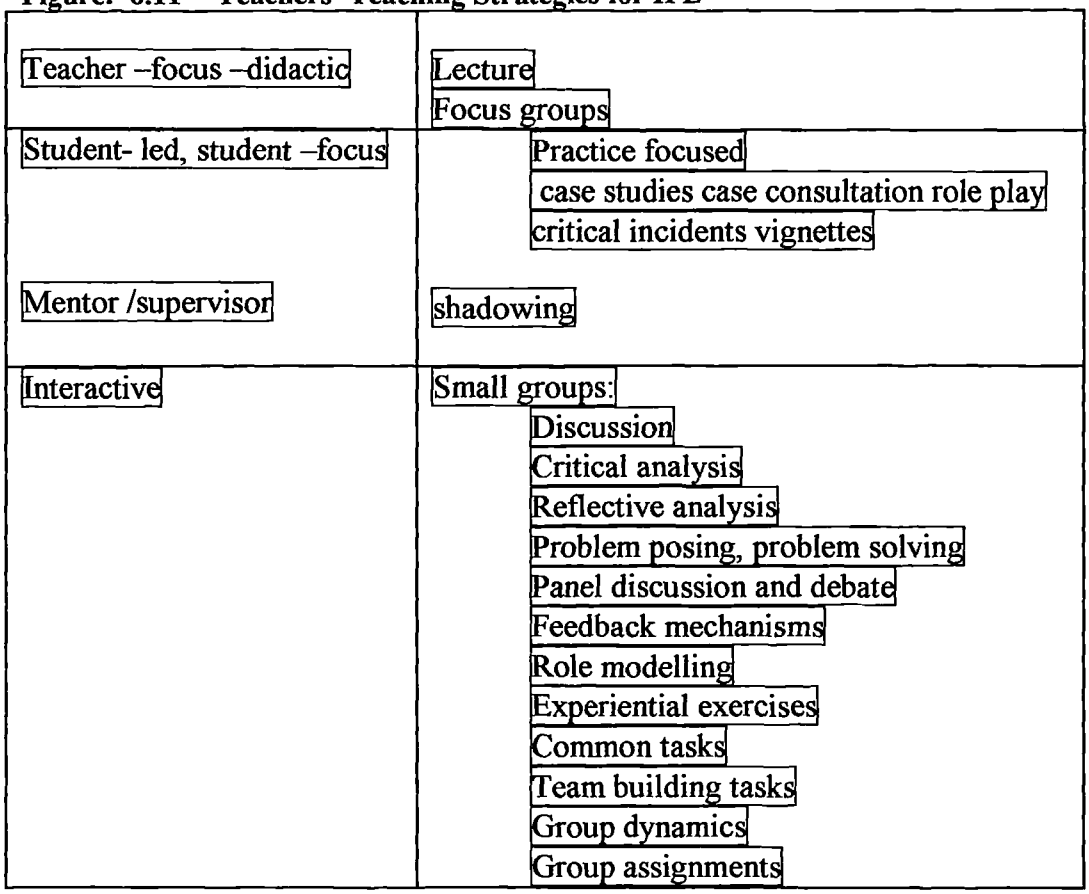
Group members were advised to work together on a regular basis. These groups were called *string groups* with the purpose of maintaining contact throughout the programme:

> ... *otherwise one can study over three years and not know anyone. My experience is that some groups mix, others do not and are unwilling to interact and cross boundaries. Modular approaches have advantages but learning can be fragmented, it is up to the teacher to emphasise interaction* (occupational therapy teacher).

6.6.1 Teaching Strategies Used for IPE

Combined data from all of the comments reflected a picture of teaching strategies that included most approaches (see Figure 6.11). Teachers moved from a didactic approach to student-centred/student-led approach to interactive processes. Teachers used varied methods appropriate to adult education. Efforts were made to develop interactive learning through group work and team building exercises. Teachers were accommodating this type of learning for mixed professional groups by splintering large groups into smaller ones. On occasions, large groups of 240 students were broken down into twelve groups. Teachers were able to use the background experiences of students to develop interaction and student involvement. This process involved several steps such as identifying past shared experiences, using experience to organise team work, identifying shared goals and deficits in knowledge, and using peer learning to fill the gaps. The skills based exercises focused on collaborative work in the practise of health and social care.

Figure: 6.11 Teachers' Teaching Strategies for IPE



6.6.2 Collaborative Teaching and Learning

Teachers used a variety of ways to facilitate collaboration between group members. Orientation to the ideology of interprofessional education was of importance. This meant promoting the programme in advance and identifying the rationale and benefits to students from the onset. Other ways of encouraging collaboration were described as investing time and effort in timetabling and raising awareness of the value of a mixed contribution to learning. Experiential learning activities and extracurricular activities were used to develop collaboration within groups.

Ways to encourage collaboration were identifying the task and maintenance

functions. Task functions were significant of the problem solving process of groups using reflection on action. Maintenance functions were those functions required to maintain the balance between task variables and variables within group processes. These functions are essential for interaction that is transparent and progressive (Brown 1988). The data yielded other categories, which describe psychosocial and professional attributes. These rely on the teacher's ability and personal traits, yet are essential for good facilitation.

In a shared learning environments the needs of minority group members or under represented professions was a critical consideration teachers needed to consider strategies to facilitate optimal involvement of all group members. This gave rise to a number of considerations and actions. The approaches used to motivate the groups related to the psychosocial domain such as valuing contributions, challenging their attitudes and having a sense of humour. Self motivation of students reflected whether they had chosen the course of study or were sent by management. The teaching strategies identified previously were used to motivate students cognitively.

6.7. Curriculum Context: Learning Milieu

Inter-disciplinary liaison between teachers of health and social care professionals and other professionals was seen as both necessary and valuable to create a suitable environment for shared learning. Interaction across professions was generally through individual networking and was seen as a strategy to expedite their own teaching. Promoting cross-professional teaching was bound within organisational influences such as current changes amidst mergers and

amalgamations, workload and sickness patterns which inhibited close interaction and evaluation of developments.

Physical resources for group work or social interaction were limited in most establishments. The teaching happened mostly in large lecture theatres and it was difficult to acquire rooms for formal group discussion and impossible to secure informal common facilities. As a nurse teacher stated: *putting students together (often to save resources) then they expect it to miraculously happen.* It would seem that the timetabling of IPE was no different to any other form of education and consequently teachers were faced with compromising to make it work effectively.

Teachers were not always aware of the group composition or their background knowledge in advance:

> *Unaware beforehand of the level of knowledge of the students; nor are the numbers of students expected to attend clear to the course organisers or me* (family therapy teacher).

Just *'putting students together'* resulted in concurrent learning for the most part; with efforts to form groups to approach either separate needs for professionals or issues for many professionals to resolve.

> *Shared learning is integral throughout not all is an active approach to sharing some of it is sitting next to each other. The principles of interprofessional education of promoting opportunity to study /work on an equal level are there all of the time. Half the time was spent on care studies the other half was linking the life cycle approach to interprofessional working* (nurse teacher).

The whole process was challenging for some teachers and the participants seemed more than conscious of the problems. When resources and group composition

were as expected teachers looked at their role as facilitators, as stated *IPE must be facilitated well by lecturers or it could be a disaster* (pharmacology teacher).

The geographical location of student groups was also a problem. This situation inhibited groups coming together within a common core module to share learning. The idealistic reasons for sharing learning were powerful but the practicalities of delivering it were wrapped into obstacles, including financial and professional obstacles. The implications for pre-registration nurse education were complicated by bottlenecks in practical areas, especially in community because of the emphasis on a health model. With a decreasing workforce and increasing student numbers to cope with:

> *The whole college's educational machinery is problematic, it hasn't sufficient staff in the community and they are overburdened* (midwifery teacher).

Timetabling in some areas was now compiled centrally and on a yearly basis. This restricted flexibility in facilitating sessions.

> *I would plump for cost effectiveness. I do see it because of the environments but I see it actually as a focus, a shared focus or shared concern, and the group themselves will respond to that. I see it in the very large groups where they are coming together en mass, four or five groups, who are doing different courses, come together for core subjects, and nobody gets anything out of the session* (physiotherapy teacher).

Mixed groups of professions were often educationally disadvantaged because of inequality in knowledge base and or dominance of one profession over others. For example, a biologist taught 30 midwives and 300 nurses as a mixed group. Group size inhibited easy access to group work, teachers frequently had to split the group into subgroups. Consequently, facilitation was problematic. In addition, the learning outcomes for different professions varied, as did the paradigms of professional knowledge brought to the classroom context by the teachers:

> *Matching of student knowledge - nurses are given thirty hours ethics and medics only two hours. Nurse teachers have a huge amount of knowledge of ethics, clinicians much less and philosopher's knowledge of health care ethics is questionable* (nurse teacher).

Potential and actual problems in meeting the needs of minority group members included a perception that:

> *Students are sometimes reluctant to look at their own cultural perspectives consequently they tend not mix* (podiatry teacher).

> *Minority group members are encouraged to participate but conformity and complacency prevents a true andragogical approach* (family therapy teacher).

The curriculum context and the learning milieu was complicated by different academic levels in the same group. Similarly, there was a great concern about using IPE at undergraduate and postgraduate levels. The evidence inclined towards the view that IPE at post-qualifying level was more acceptable than post-qualifying because the group members could cling to their experiences as a focus for discussion.

> *People are better able to understand the importance of interprofessional learning and working together. Although, I accept they do not always want to do it* (dietetics teacher).

A typical reason for using IPE at postgraduate level was how teachers could facilitate learning:

> *Give examples for them to work on which are outside their chosen discipline. Easier with postgraduate groups as they are smaller and they have established their professional identity and commonality of purpose which undergraduates do not perceive* (occupational therapy teacher).

Teachers from different backgrounds felt that undergraduate students required time to socialise into their chosen profession before embarking into IPE. Students

need to develop self-confidence and a sense of identity with their own profession. Those who tried to mix undergraduates found it extremely difficult because of practicalities and sometimes through student evaluation accepted that it just did not work.

> *Shared learning is definitely much harder and difficult to plan creatively for pre-registration students as each distinctive profession within branches needs the opportunity to socialise into and 'bond' with each other* (midwifery teacher).

> *Shared learning is far more appreciated at postgraduate level, at undergraduate level there is so much for them to update and build on to increase their knowledge before sharing learning* (radiography teacher).

It was appreciated that mixing undergraduate and postgraduate groups within a multi-disciplinary context enhanced shared learning:

> *It (shared learning) occurred through discussion and listening and actually seeing the wider issues, people were seeing things from a different perspective. From one session, people would pick up different ideas and there were lots and lots of group discussions. It was the richness of the day because of the ideas expressed* (researcher).

There was also a negative dimension to this. If the reasons for combining undergraduate and graduate students were not explicit, competition between members created anxiety. Consequently, they found refuge in their homogenous group.

A key factor was the similarity or difference in subject content for the mixed group. This signified that the greater the gap between their knowledge the greater the difficulty in sharing learning:

> *The key problem is whether learning needs are similar if required content is similar for all groups, there is not a problem. Nevertheless, if you are trying to teach something to people with widely different knowledge bases or very different learning needs then individual contract learning strategies must be used which reduces the value of shared learning. The*

> *alternative is insufficient application or depth and poor learning satisfaction* (occupational therapy teacher).

Students were not always able to synthesise the new knowledge with their own area of practice. Recognition of the influence of professional socialisation and culture meant teachers had to compensate by using strategies that were specific and relevant to each specialism.

A common denominator between group members mostly dictated the purpose of a shared learning milieu and how learning fitted with such an environment. Moreover, the data suggested that the methods used did not always match *group learning* but mirrored *concurrent learning* using common or core subjects. This poses the question of what other reasons might warrant shared learning other than when there is common ground? One teacher proposed that even bringing different people together from the same background (in this case neonatal care), can be useful to expand their thinking:

> *We could bring them together purely as a challenge because they are used to thinking of just neonates. It is such a speciality they think the whole world revolves round neonates and there are actually other issues to be looked at such as community issues and the broad health reforms* (nurse teacher).

Changing entrenched attitudes that are formed through professional culture and socialisation into that culture is extremely difficult. The whole issue of sharing learning milieu brought this to the forefront. Whether students were already familiar with their specialism or not made little difference to their value and belief system. The teacher's function in dealing with culture, attitudes and stagnation in thinking was a major challenge. One proposition was to create

generic titles for professions, whereby all members had a focused function with their own specific attributes to endorse:

> *It would be good if a common core could be used as a route for higher education and a health studies degree, with awards specific to the profession. In my experience in mental health, we all called ourselves mental health care professionals within the multi-disciplinary team, and we saw each other with specific skills to provide a service to the clients. This can happen if there are no professional rivalries and people are not too concerned about losing titles* (psychiatry teacher).

> *Examination of the professional and voluntary tribes, allowing issues such as; work, gender, race, and sexuality to surface. The balance of reflective study module and observational studies is also instrumental in engaging interprofessional and collaborative approaches* (nurse teacher).

6.8 Characteristics of IPE

This section reflects the teachers' perceptions of the definitions used for IPE and shared learning. The literature at the time of the study frequently related to 'shared learning' as the key concept within interprofessional education. The two terms were often used interchangeably.

This definition of shared learning used in the study was:

> *A planned approach within a curriculum leading to shared knowledge and experience between groups undertaking teacher preparation programmes.*

As the second stage of data production included a wider audience of already qualified teachers, the definition concluded with the following:

> *....between groups of health and social care professionals undertaking pre and post qualifying education.*

Interprofessional education was defined as

> *Any educational initiative created for health and social care professionals for the purpose of 'learning together to work together'.*

The majority of the participants (82%) agreed with the definition of IPE. Polar views were expressed which positioned the definition as too general or too specific in nature. Those who perceived it as too specific took the view that the term *interprofessional* omitted issues such as the wider remit of interagency work, role identity or the nature of interaction within the learning process.

> *Perhaps this is a narrow definition, is it just about health and social care professionals, am unsure of the meaning of 'learning together working I would prefer 'created by and for health & social care professionals'. The use of ' for health and social care professionals' suggests a passive role* (social work teacher).

The polar opposite view positioned IPE within the confines of specific objectives:

> *It is too general. It does not distinguish between deliberately tackling interprofessional issues (boundaries, role related or practice related) and simply sharing a common curriculum* (biochemistry teacher).

> *I wonder if an aim of interprofessional education should be the benefit of client care and to have some ideas about purpose such as increased morale* (medical teacher).

Some teachers offered little distinction between terms such as multiprofessional, and multidisciplinary, interprofessional, interdisciplinary or integrated education.

> *The topic raises the issues of how extensive should the integrated education be, across all disciplines I haven't thought about it before and your definition sounds as acceptable as any other I might read* (podiatry teacher).

The contradictory nature of the definition of IPE was evident. Apart from the debate that not all health and social care workers are called professionals, it was

clear from the data that more than these professionals were involved. Sometimes the group composition consisted of non-professional categories with people from varied occupations and carers who were outside any paid occupation:

> *Health and social care needs to be defined to ensure people are including the same people. There is the debate that not all health and social carers are 'professionals'. Should all shared learning be included in interprofessional training? It may include colleagues from education and other sectors which might not be included in the little 'health and social'* (nurse teacher).

> *Apart from the argument of what is a professional? The definition appears narrow and restrictive, as many unpaid carers attend some of my courses, your definition appears not to include such valuable resources to the delivery of care* (social work teacher).

> *Perhaps limiting, some learning may extend beyond 'health and social care professionals' (depending on your definition of social care). I teach counselling and counselling skills. We have had prison officers on the courses which is beyond the remit of your definition* (social work teacher).

> *Shared learning is a broader definition than this and could encompass non- professionals for example people studying non vocational degrees and allows exploration of different perspectives on a number of theoretical and practical issues. It should enable a broadening of ideas* (occupational therapy teacher).

> *Interprofessional education could include other groups for example, health officers and there is considerable scope for IP with the teaching profession* (speech & language teacher).

Alternatively, some educational initiatives were within the boundaries of unidisciplinary groups. Teachers involved in nurse education described two distinct camps. Some viewed the nursing profession as *interdisciplinary* and or *interprofessional* because of the varied branches within it. Others perceived nurse education as unidisciplinary and outside the bounds of IPE. This raised the issue of how people see themselves as professionals:

> *Shared learning is more than sharing between professional groups in health and social care. It also involves sharing inter-disciplinary for example, there is a range of groups within nursing. It relates to how people define their professional identity as much as their role. As you may note, I am on three parts of the UKCC professional register and I strongly feel that I draw on all aspects of experience in fulfilling my present role. I am sure this is true of a number of nurses* (nurse teacher).

> *At undergraduate level students are not professional and have varying levels of professional entity* (radiography teacher).

A valid criticism of the definition lay in its generality. It does not distinguish between deliberately tackling interprofessional concepts and sharing of a common core curriculum for professions. It is obvious that many educational initiatives take the guise of IPE, but in reality create conscription rather than choice in learning.

> *It ought to be about improved mutual understanding I am not sure whether the focus on 'learning together to work together' is correct* (medical teacher).

> *I question your assumption of 'learning together to work together' The latter may not happen at all, unless your definition of 'work together' is physiological rather than psychological* (midwifery teacher).

> *Interprofessional education is more than just working together - it provides insight into the foundations of each professional group and allows exploration of different perspectives on a number of theoretical and practical issues. It should enable a broadening of ideas* (nurse teacher).

The axiomatic nature of *learning together to work together* was the most frequent criticism of the definition. This implies a close connection between professions in practice based learning and a definite purpose for IPE. The type of learning described in this study did not suggest that this target was achieved. Learning together *to improve mutual understanding* was seen as more realistic. A substitute

phrase was given in learning to learn together or a learning culture for sharing together.

The term *curriculum* was included to envelop both classroom and experiential learning. Some participants opposed the term *curriculum* because it isolated informal learning. The most appropriate milieu was the workplace, where interprofessional experiential learning could be nurtured. Nevertheless, most of the stated initiatives occurred only within a classroom milieu.

In defining IPE it was proposed that no professional group have ownership exclusively of a particular area of knowledge or expertise. Additionally, the importance of learning to appreciate the expertise and knowledge of other group members was emphasised. In the words of a teacher in radiography:

> *It is not just 'learning together' education implies 'knowledge' in its broadest sense. Students share learning to gain knowledge and utilise a range of experiences, as well as beginning the process of learning to work together.*

The need to elaborate on what is learnt in 'shared learning' was emphasised. Common issues such as client problems, communication skills and management were examples of the focus of interprofessional education. Whatever the subject matter there was more meaning behind the concept:

> *The use of the word learning, it is more than sitting together in the same place. Shared learning is the culture exchange and involvement in problem solving. You need to elaborate on what is being learnt, created, or encouraged to happen* (pharmacology teacher).

The definition of IPE was also questioned in relation to definitive outcomes. Client related outcomes were most prominent, followed by partnerships, collaboration and teamwork. A prerequisite to collaboration and partnerships lies

in the broadening of one's own knowledge and belief system. When a sound interprofessional ethos existed, morale among workers was said to increase.

> *There are far more pragmatic reasons for interprofessional education. One could add: what interprofessional concepts mean - partnership, collaboration, interagency, teamwork, also look at how the different professionals address ideology, ethics, values, anti-discrimination and conflict* (psychiatry teacher).

Defining the terms was not confined to the educational aspects alone. Cognisance was given to the external forces, such as recognition of the differences between voluntary and private agencies and professional paradigms. The question of who is defining IPE was viewed as essential to its composition, for example, it was suggested that students, lecturers, managers or the fiscal stakeholders determine the purpose of IPE.

Deciding what was meant by interdisciplinary, intradisciplinary, unidisciplinary, multidisciplinary, multiprofessional, inter and intra professionalism was immersed in personal knowledge and experience. The greatest semantic overlap was noted in the use of multiprofessional and interprofessional.

Shared learning was calculated as how much students learnt from their peers through a learning opportunity that included interaction, listening and gaining from each other. Cynically it was stated that the term is interpreted as *an artificial definition of shared learning* within universities as a pretext for cost-effectiveness. It was suggested that the word *initiative* in the definition should be substituted by *process.* Shared learning was substituted by *shared values* and perceived as psychological rather than physical.

The additional attributes of shared learning given by teachers in health and social care are categorised as *interactive, outcome oriented, professional and psychosocial attributes* (Figure 6.12). The interactive category has two subsets, dialogue and active participation. Attributes such as *outcome oriented* centred focused on client, education and policy components. *Professional* attributes were role related and team building related. The final category *psychosocial attributes* has two subsets intrapersonal to denote *between* people and interpersonal to indicate personal components.

Some of these attributes were conditional and dependent on other factors. The context of shared learning was extremely important in identifying components of shared learning. Other influencing factors were the degree of preparation by the teachers involved and whether it was facilitated creatively and sensitively to the groups' needs. Shared learning was not without personal tensions, as the individual's own perspective was challenged and this had caused people to rethink their career plans and change jobs.

Figure 6.12 Attributes of Shared Learning

Interactive

Dialogue	Active Participation
Creates a lot of discussion Sharing experiences amongst students Allows students to express views Discuss and understand own roles and agency's Challenges established working practices/attitudes Assists in decision making Broadens both learners and educators views Develops communication and support channels Group experiences discussions are more productive	Promotes collaboration in working Allows sharing and challenging of common issues Creates interdisciplinary co-operation Increase student participation Personal development of staff Joint learning activity for teacher and students Facilitates the personal growth of the teacher Promotes collaboration and co-operation Practice collaboration in a safe environment Enriches facilitation of professional specific groups.

Outcomes oriented

Client-oriented	Education-oriented
Opens up the parameters of patient needs Enhance patient/client care Encourages a holistic approach to care. Better use of resources Provides a framework for research to lead to effective health care Helps focus participants on the client rather than their specialist contribution Should ensure quality of health care services	Leads to better understanding and use of knowledge and information at wider level **Policy -oriented** Can be a cost cutting exercise Increases staff work load and assessment load.

Professional

Role related	Team building
Challenges assumptions of other professionals' skills Assists in setting guidelines of professional roles Reduces overlap of effort Promotes confidence in 'professional' role Contributes to role development Promotes mutual understanding of roles Encourages students to recognise their role and functions Practical and convenient for disciplines in same profession It allows some professions to discover their worth Gives teachers street credibility Leads to support of minority members in groups	Promotes multidisciplinary team work and cohesion Promotes teamwork Helps create networks to facilitate care. Assist with autonomy membership with team concept Assist identification of 'key' leaders Changes relative professional power issues Adds varied perspectives to shared problems Able to identify each of the team members as equals Helps interprofessional networks in practice

Psychosocial

Intrapersonal	Interpersonal
Develops interprofessional skills Promote more meaningful learning Encourages teachers to have a broader perspective Creates a deeper level of interdisciplinary distinctiveness Creates a culture of respect and safety Increases social synergy Professional specific issues (PBL) Challenges stereotypical and granted values Clarifies values	Reflection Creates self-conflict in a positive way Increases reflexivity Increases self awareness Motivating because interesting Enriching in experience and rewarding. Satisfying for teachers Safely exposes personal limitations Enhances personal development

6.9 Summary of Chapter

The qualitative data gave a broader picture of what the teachers perceived as significant to them in planning, implementing and evaluating interprofessional education programmes. Teachers had gained a great deal of knowledge and skills in dealing with shared learning environments for health and social care professionals and significant other non-professionals.

The data gave a profile of shared learning in the context of Centres for Teacher Education, Colleges of Nursing and Midwifery, and Higher Education. Economical influences as opposed to educational driving forces in organisations had enormous impact on the implementation of interprofessional education. The beneficial outcomes of IPE were prominent and identified as *role related, group oriented, problem oriented, and collaborative*. Nevertheless, smooth progression of programmes was hindered because of disregard for the type of programme, the group composition and the specific needs of group members. The problem was compounded by ergonomic factors within organisations and fiscal arrangements between stakeholders.

Teachers were mindful that IPE could dilute barriers between professions and develop mutual understanding of roles. Yet in the practice of IPE there were many obstacles. Attitudes of staff and students were not always positive towards the innovation. Cynicism stems from a lack of organisational commitment to the philosophy and policy for IPE. In addition, a lack of preparation of groups and teachers themselves meant that the process was situational and dependent on motivation of the facilitator and group. Most teachers had no preparation while

equally they desired it. Teacher perceived that students were ill prepared also. Specific preparation of teachers was considered necessary to facilitate groups, examine discourse and boundaries between professionals and develop appropriate teaching strategies for interprofessional groups.

Professionalism was described from the students' stance. Teachers were concerned about using IPE at all academic levels. The needs of a novice in a profession were isolated from the needs of experts in their field. One side of the argument was that the novice must acquire their own professional identity first and foremost. The restraints of curricula for pre-qualifying professionals made it difficult to plan and implement. These restraints were due to statutory rules and organisational and physical obstacles. The solution to this meant that *common core* subjects were used as IPE and subsequently group size became a problem for discourse.

As educators of professionals who must meet the regulatory requirements for practice, teachers were in a situation where they were expected to be the *expert* in teaching and *expert* in practice. The nature of IPE meant that their planning of teaching sessions had to incorporate multiprofessional paradigms. For some this had created cognitive dissonance as to how to abide by organisational policy and feel contentment with their own role. There was significant debate as to the typology of a teacher for IPE. The models or typology presented were fourfold. First, there was a *specialist* teacher who taught their subject across different groups. Second a *generic* teacher who was more adaptable to general principles and taught groups in this manner while accommodating specialist application if applicable. Thirdly, there was a *team* approach or *joint* approach with one or

more colleagues to integrate professional paradigms. Finally, there was the teacher who functioned as both *teacher and professional practitioner* and whose role bridged across theory and practice. The types of functions performed in this capacity were varied.

Despite the obstacles encountered, teachers were generally in favour of IPE and had made huge efforts to accommodate students despite the extra time required for planning and implementation. A majority of teachers used what they described as particular teaching approaches for mixed professional groups. The models used for teaching spanned the four models described by Joyce & Weil (1996). Teachers aimed to facilitate *group learning* through models of reflection and interactive processes. Collaboration between group members was encouraged. Both psychosocial and cognitive perspectives were noted in how teachers motivated mixed professional groups. The outcomes were dependent on the facilitator's style and the suitability of the learning milieu.

There was general agreement with the definition of IPE. The area of most contention was in the catch phrase *learning together to work together.* The evidence cannot suggest that the type of learning teachers facilitated would impact on professional practice. Some of the reasons for this conclusion are obvious. Firstly, the aims of this study were not inclusive of student or practice evaluation. Secondly, teachers viewed the groups as unlikely to work together, as they were not selected from specific environments for a common purpose. Thus, chances of working together in the future were unpredictable. Teachers aimed to create knowledge skills and attitudes towards teamwork and holistic client care. This was evidenced in how they described ways to encourage collaboration.

Chapter: 7

Discussion and Conclusion

Introduction to Chapter

This chapter discusses the main findings of the research in relation to the aims of the thesis. The chapter begins with a résumé of the aims of the study and the key findings in relation to these. The common themes that emerged from the data create the platform for discussion. The results are discussed in relation to the literature and the limitations of the thesis are addressed.

The overall aim of this thesis was to unravel the parts that constitute interprofessional education and re-structure the evidence within a framework reinforced by theory. The thesis examined IPE and shared learning from the perceptions of teachers in teacher education centres, colleges of nursing and higher education. The evaluation took the form of three surveys using mixed methods of quantitative and qualitative data collection and analysis. The data collection for survey one and two took place in 1994-1995 and the data for survey three was collected in 1996-1997. The findings from the investigation into ENB approved programmes are reported elsewhere (Mhaolrúnaigh et al 1995).

7.1. Interprofessional Education in Teacher Education

Nurses, midwives, and health visitors who wish to teach have to meet the educational requirements of the statutory bodies. Consequently, institutions are approved as centres for teacher education for these health professionals. The

interprofessional nature of teacher education was of interest to the ENB as policymakers. The first stage of this thesis sought to identify the nature and extent of interprofessional education in the preparation of nurses, midwives and health visitors for their teaching roles. The first survey aimed to:

1. *Identify the extent of interprofessional education and shared learning in ENB approved programmes for teacher preparation.*
2. *Examine the content and context of these programmes in relation to interprofessional education and shared learning*

The data was drawn from a postal survey of all the institutions approved by the ENB at the time of the study. Seventeen centres were included in the data analysis. Interviews with course leaders from five centres gave additional qualitative data to examine the context and content of programmes.

The conclusion drawn from this survey was that teacher education was set in a modular system where many different professionals could share the same learning milieu. Education programmes within teacher preparation centres had evolved to create easier access, accreditation for prior experience and flexible modes of learning how to teach. Nurses, health visitors and midwives were more likely to undertake this form of teacher education than other health and social care professionals because of the requirements of professional bodies (ENB 1999; UKCC 2000). At one level these newly created structures brought with them enormous potential to develop learning processes that helped to breakdown professional barriers and develop mutual appreciation between professions (Weinstein 1993). However, there were also many restrictions for true sharing in learning to occur, partially due to the very nature of the programme structures

within modular systems of education (Barr 1994b). Nonetheless, course leaders were committed to the ideology of shared learning and tried to accommodate the needs of all.

Most centres were preparing teachers and students within shared learning milieu. Specific preparation for teaching interprofessional education was mostly by experiencing peer learning in multiprofessional or multidisciplinary groups. The results also suggested that the teachers and students within these centres were generally in favour of shared learning environments.

The type of learning described emulated concurrent (Chang & Simpson 1997) and co-operative methods (Johnson et al 1991) within multidisciplinary and multiprofessional education. The teaching strategies used by teachers represented the types of learning methods described by Barr (1996) as received learning, action based and simulation based learning. There was no evidence to suggest that the type of education delivered in the centres matched or could match the notion of interprofessional education as a planned activity for learning together to work together (Barr 1994a).

The second survey aimed to:

> *Investigate the practice and effects of interprofessional education and shared learning in contrast to the separate approaches, from the perceptions of student teachers, newly qualified teachers, experienced teachers, teaching staff involved in the teacher preparation programmes and education managers within nurse, midwifery and health visitor education.*

This aim was addressed by postal questionnaires and interviews of new teachers who had attended centres for teacher education and taken up employment in

colleges of nursing and midwifery. Some mentors and managers also gave their views through telephone interviews. The data was compared to the data for the first survey.

The new teachers' perceived that their preparation centres were not as strongly in favour of shared learning as they themselves were alleged to be. However, most new teachers felt adequately prepared through their teacher preparation programme to develop teaching strategies, motivate mixed groups and provide examples for learners in shared learning environments.

The practice and effects of shared learning in teacher preparation were reflected in the ways in which new teachers endeavoured to use the strategies they had learned in their programmes when teaching students in colleges of nursing and midwifery. The new teachers gave accounts of their approaches to facilitate sharing between groups, such as participatory learning, and the use of reflection on their own roles and practice. Nonetheless, the teachers' ideology of shared learning was not sustained in practice partly because of the group composition and group size. Examples of good practice were found in relation to facilitator's style, use of reflection on practice, and the teachers' abilities to articulate versatile issues surrounding health. References were made to published works such as Schon's (1983; 1987) views on reflection on action and Benner's (1984) model of decision making from *novice to expert.* Teachers used these and adult education theories to develop knowledge and skills at different stages or levels in education.

The type of education in colleges of nursing was unidisciplinary at pre-qualifying level with multiprofessional developments at post-qualifying level (Robinson & Leamon 1999). This result indicates that professions were beginning to respond to the problem of fragmented services and use post-qualifying education as a basis for multiprofessional education (Barr 1994a).

Overall, it may be concluded that, for the majority, shared learning was evaluated positively by newly qualified teachers as a result of their experiences on the teacher preparation programmes and by more experienced teachers working as mentors and managers in colleges of nursing and midwifery. Respondents indicated more positive aspects to shared learning than negative ones and generally, the impression of having benefited through their experiences was noted. Stanford & Yelloly (1994) found that students in IPE gave similar responses, but the main problems were cost, complexity and fragility of collaborative planning.

The key lesson learnt from surveys one and two was that regardless of the terminology applied to the learning milieu, the same philosophy applied. This means that the terms unidisciplinary/ multidisciplinary or interprofessional were of little importance to the delivery of programmes (Jones 1986). These findings endorse the overall conclusions of this thesis.

7.2 Interprofessional Education in Higher Education

The third survey aimed to:

- *Investigate how the teachers of health and social care professionals viewed, experienced and evaluated interprofessional education and shared learning.*

The survey gave a profile of IPE within higher education and the perceptions of teachers (n=246) from varied health and social care backgrounds. There were several lessons learnt from the findings that are significant to future developments of IPE.

Nature of IPE as an Innovation

The operational definition of IPE for this study was stated as:

Any educational initiatives created for health and social care professionals for the purpose of learning together to work together.

The majority of teachers agreed in principle with the above definition. There were other views expressed which suggested that the definition was overly rigid and isolated non-professionals from the learning milieu. This questions whether the title interprofessional education should only include *between* professionals and supports the need to address collaborative learning as *among* group members as more appropriate when other communities outside the professions partake in the learning milieu (Bruffee 1993).

There were opinions, which viewed the definition as exceedingly universal because of the axiomatic nature of *learning together to work together*. This might be a goal of IPE, but, in reality, whether group members functioned

collaboratively afterwards because of sharing learning experiences was not something that was monitored or measured. Presently few programmes have been evaluated in the UK (Barr 2000; Barr et al 1999). If the definition of interprofessional education is said to comprise *learning together to work together* the evidence supports interprofessional practice as inclusive of the sum of its parts. The perceptions of the teachers denote otherwise. Even though many of the teachers had some role in practice based education, most of the programmes on offer were not specifically focused towards interprofessional practice and sharing learning was not extended formally outside the classroom.

Shared Learning

The operational definition of shared learning used in this study was:

> *A planned approach within a curriculum leading to shared knowledge and experience between groups undertaking teacher preparation programmes.*

The results support the hypothesis that *shared learning* is a misleading notion. The expression corresponds to learning that has happened in the past and has been evaluated to signify a cause effect relationship. From the teachers' perspective shared learning meant the modus operandi of learning how to interact in order to dilute boundaries and transcend individualistic independent professional knowledge bases. For this type of sharing other attributes were specified by the teachers. These were categorised as *interactive, outcome-oriented, professional and psychosocial attributes* (Figure 6.12). The interactive category had two subsets, dialogue and active participation. Attributes were also outcome-oriented towards the needs of the client, education and policy

mechanisms. Professional attributes were related to role and team building. The final category psychosocial attributes had two subsets: intrapersonal, to denote *between* people, and interpersonal, to indicate personal components (Tuohy 1999).

Teachers Values and Beliefs

Teachers were at the forefront of IPE without adequate support or preparation for their task. The findings indicated that teachers needed to experience this type of learning themselves and learn from and through their experience (Jones 1986). Professional development for teachers should include learning about the concept of IPE and learning how to deal with groups of mixed composition. This requires an inventory of different skills for group learning such as facilitating the group to expand language to a *new language* (Bruffee 1993) and through the processes examine common and uncommon ground.

IPE as a new concept for health and social care professionals has several consequences for change if taken seriously as a way forward for education and practice. Teachers' views reflected two standpoints, one as *potentially the correct thing to do* to influence client care, secondly, that it is the *politically correct thing to do* but has too many negative connotations attached. Their understanding of the concept reflected the difficulties of fitting a new concept into an old structure without investigation into the human or physical resources or sufficient advance planning. Accordingly, the management of innovation resulted in a theoretical exercise leaving some element of disillusion and frustration in role functions.

The teachers showed emotive views towards IPE as either rewarding, valued and involving or, on the contrary, intimidating, scary and challenging. There was firm recognition that professions become entrenched in their own value systems and this was a major obstacle for collaboration and IPE. The rapid movements towards integration of professions created suspicion and suspense for some, especially with the potential of reducing human resources. There was evidence to suggest that for interprofessional education to succeed, first and foremost the teachers needed to believe in it and demonstrate solidarity as ambassadors. Still, the debate of professionalism as opposed to interprofessionalism was not resolved.

Professional and Interprofessional Perspectives

Interprofessional education was considered as a pragmatic way forward provided all professions are cognisant of the potential benefits it could unfold. The majority of teachers in the study strongly agreed that sharing learning environments could promote mutual understanding of roles. Teachers gained a broad perspective of others' roles through team teaching or collaborative teaching. Peer support and networking happened across some faculties albeit mostly informal.

The first task for teachers was to help professionals' gain mutual understanding of roles; consequently, this was a considered aim in teaching. The methods employed to achieve this aim were reflection on role functions, client-oriented problem-solving through simulation, and group discussion. Accomplishing this within a learning milieu was not easy as novice learners were unfamiliar or

gaining familiarity with their own profession and often the qualified practitioners were engrossed in their own worlds.

Tribalism Versus Collaboration

Teachers were in a difficult position as they were mutually reliant on their co-teachers for IPE to function. Ironically, simultaneously some of the teachers were experiencing the same problems of conflict and uncertainty from their own colleagues. The issues were embossed in perceived hierarchical or professional barriers between teachers. Concern lay in maintaining professional individualism yet living with a philosophy that emphasised dilution of boundaries between professions (Julia & Thompson 1994a). A divergent view was that IPE reinforced professional stereotypes rather than dissolved them. For some *contested territory* (Hugman 1995) was evident in educational establishments where claims to intellectual property were prominent and IPE met with resistance. The teachers reinforced Hugman's (1995) opinion that boundaries and divisions between health and social care professions are shaped by their claims to specific knowledge and skills but also by the history of organisational and policy developments of the welfare state.

The fear of loosing professional specialist knowledge and skills was measured against the value of interprofessional education. The option was for professions to share, complement each other and recognise the differences rather than emphasise the common ground between them. Certainly, common ground manifested as the core of IPE. This suggests that set principles are essential for all and not specific to any one profession. This isolates the population with *local*

knowledge (Knapp & Associates 1998) or *community knowledge* (Bruffee 1993) from taking a place in IPE.

Approaches to Encourage Collaboration

Teachers were cognisant of group learning for developing collaboration and described several aspects that fit task and maintenance functions of groups. Their focus was to breakdown boundaries, dissolve tribalism and resolve conflict. There were other essential mechanisms in use such as psychosocial functions, which focused on how the facilitator dealt with groups using educational psychology and educational theories in their teaching and learning strategies. These techniques served as motivating factors for students in IPE. What the findings do suggest is that the task and maintenance functions are more holistic than described. The task functions were group focused through problem-based learning. The maintenance functions were focused on dilution of boundaries and conflict resolution in particular. Two other categories developed that focused on the professional and psychosocial functions of the facilitator.

The link between these constructs and the attributes of shared learning was noteworthy. The ideology of shared learning milieu supposed interaction and dialogue through active participation. It should be outcomes-oriented towards educational policy and client welfare. The professional aspects of shared learning milieu supposed that the teacher focused on roles and team building and the psychosocial element focused on both intrapersonal and interpersonal development.

The structure of IPE reflected a lack of commitment from management at higher organisational levels and of collaboration from within and outside educational establishments. Moreover, teachers worked towards implementing policies with severe constraints resulting from this lack of commitment. This supports the statement that:

> *Interprofessional programmes within universities...operate in an environment that is in varying degrees indifferent or even hostile, to the enterprise* (Knapp & Associates 1998 p19).

This type of education demands intense collaborative efforts from the organisations, teachers and students, consequently it:

> *immediately stretch(es) individuals from both inside and outside university walls beyond their comfort zone* (Knapp & Associates 1998 p198).

The structure of programmes, even when labelled as IPE, showed scant resemblance to concerted efforts through joint planning by collaborative bodies. Collaboration between stakeholders both in-house and externally was lacking at strategic management level. This caused a breakdown in policy formation and implementation. Issues such as fiscal arrangements, ergonomics, and a lack of resources were profound. The concept of learning organisations (Senge 1990; Cope 1998) was not evident from the teachers' views of management or implementation of IPE policy.

The reasons for IPE policy were seen as economical and educational; these commodities were frequently viewed as competing driving forces. The economical facets were the competitive market in education, pooling of resources, decrease in student numbers, quantity above quality and cost

implications. The reduction of cost and repetition of work were seen as a high priority outweighing any impact of large groups (Barr 1994a). The driving force was primarily shown in teachers' altruistic attitudes towards the potential impact on client care. This created enthusiasm to share and work together. The results highlighted a concern that change was made for change's sake and or that interprofessional education was in vogue.

This is borne out by the types of groups which were combined and for which subjects. The size of groups and the problems of timetabling show that the process was not a true planned strategy with proactive resolve to create the best environment. The most difficult aspects were managing the education and balancing the vested interests of university colleagues and the professional body requirements for the courses. Even so there were those who felt that this concept has lots of potential when group size was small enough for interactive learning (Gilbert et al 2000; Barr & Shaw 1995). There was no doubt that IPE was invested in a modular structure. Hence, movement of students through a flexible educational process in itself can stifle opportunities for group cohesion. Even perseverance by teachers to manage IPE through group work caused inconsistency, as group composition was not always known in advance.

Group composition or *substantive foci,* the term used by Knapp and Associates (1998), was not only interprofessional but represented non-professionals also. This suggests that the expression *interprofessional* is inappropriate. Group structure was determined by recruitment factors in conjunction with willingness by professions to partake. Practical reasons of workforce planning inhibited

management in service to release staff. Group composition was ad hoc, yet teachers believed in the importance of *equality of professional representation* within groups. This meant to have equal representation of professions and equal opportunity in participation, ideally of similar academic levels. In reality, groups were varied and could vary in academic achievement. Group composition created low representation of *minority groups,* whom the teachers perceived to be dominated, intimidated, inferior or lacking confidence to participate.

Models of Teaching and Learning

Teachers agreed that IPE could enrich the learning process. Nonetheless, IPE, for the most part, was implemented into an educational model of *concurrent learning* where individuals worked with peers yet engaged in individual goals. It was evident that the types of teaching and learning described in this study reflect the models of teaching and learning outlined by Joyce & Weil (1996). Problem Based Learning (PBL) and reflective learning were regularly used. These methods were used to develop group cohesion and interaction. There were some examples of *group learning* (Chang & Simpson 1997) when common goals and values were identified. However, there were several obstacles to group learning, for example, the group composition, differences in academic level, subject content and planning issues, such as, timetabling.

Formal mechanisms to evaluate shared learning were not evident. Instead, the teachers concerned dealt it with implicitly. The common approach was through feedback from groups and feedback from peers. There was scepticism as to whether students evaluated IPE *beyond feeling that it is a good thing to do.*

Interdependence (Boud & Griffin 1987) between the teacher and learners happened more by default than planning. The teacher learnt by facilitating and facilitated by learning through the group interaction. Interdependent learning as integrated learning in the wider community sense was not transparent.

Teachers were cognisant that many of the methods used to facilitate IPE were significant to any adult learning that included group work. However, to develop the educational initiative teachers were obliged to invest in planning time, and gaining understanding of other professional stances. Students' experiences were used copiously to create interaction between professions. If students are exposed repeatedly to the same process where their viewpoints are reiterated the wheel could revolve without *new learning* for individuals.

There was no evidence to show that IPE had accomplished the sum of its parts as seen from the teachers' perspective. Thus, the findings support the hypothesis that IPE is less than the stated sum of its parts.

7.3 Discussion

Interprofessional education results from an ideology that professions learn together with the object or goal of cultivating collaborative practice (CAIPE 1997; Barr et al 1999). Although systematic reviews by Barr et al (1999) have found some evidence to support this view, frequently the characteristics of IPE are stated from an idealistic rather than a realistic position. Unless the terms interprofessional practice and interprofessional and multiprofessional education

reflect the true meaning behind them the same confusion will exist for some time to come.

One view is that multiprofessional by its composition is content and context specific, using the common ground between professions as the focus for learning whereas the focus of interprofessional education is *collaborative* learning. Alternatively, interprofessional education has been described as a subset of multiprofessional education (Barr et al 1999; Harden 1998). Another view is that such is not the case but that IPE has its unique components (Knapp & Associates 1998).

If the purpose of multiprofessional education for professionals is *common ground* through cooperation with each other, the assumptions are that there is overlap in the determinants of health and social care professionals' knowledge and practices. If such is the case, there are two particular implications for educational policy:

1) Should the common ground be used for developments or should the common ground be desolated by demarcation of roles?
2) Should the idea of collective skills be valued and nurture generic health and social care provision?

Multiprofessional education in this thesis referred to a *common ground* model. This suggests that there is a need to build bridges, but that restructuring or repair work is not required. The problem lies in communication and coordination (Lawson 1999). In addition, it means understanding that the same message can be

interpreted differently by different professions (Rake & Matthewman 1997). This means building horizontal bridges across vertical structures (Casto 1994).

Building bridges through competency based learning for multiprofessional education (Engel 2000) and performance indicators of good practice (Rake & Matthewman 1997) reflects this need for collaboration. Engel (1994) suggested 'enabling competencies' for team members to adapt to change and as part of continuing personal and professional growth as teams. Engel (2000) asks the question *will the new century be able to afford the present mix of health professionals?* He places the responsibility on higher education institutions to prepare students for the future. He proposes that this preparation should include *generic* competencies for adapting and managing change and participating in change. These changes are not professional specific only, but include changes in society in general.

Knapp and Associates (1998) identified core collaborative competencies for IPE to include; sociocultural diversity, understanding collaborative practice, intrapersonal awareness and well being, interpersonal relationships, group processes and group dynamics and organisational savvy. In addition, they suggest that for people to be adept in empowering others they require skills in reflection, inquiry and action research. This suggestion of something greater than individual competence can easily equate with the work of Senge (1990), who delves deep into the concept of mastery and emerges with a definition that has not been recognised significantly in the health and social field:

> *Sadly, the term ''mastery'' suggests gaining dominance over people or things. But mastery can also mean a special level of 'proficiency'. A ''master'' craftsperson, for instance, doesn't dominate pottery or weaving. But the craftsperson's skill allows the best pots or fabrics to emerge from the workshop. Similarly, personal mastery suggests a special level of proficiency in every aspect of life, personal and professional* (Senge 1990 p142)

Competency based approaches would be limited if skills to practice were the requisites. Competence in practice denotes that the individual reaches a level of attainment and is not necessarily required to continue developing professionally. By creating 'levels' of practice, are we assuming that the individual reaches some sort of peak in practice development. Conversely, if we look at *advancing* interprofessional practice we are suggesting more than the competence required to practice.

The model of interprofessional education in this study denoted collaboration between professions. Nonetheless, it fell short of one of its key components *working together.* The transient nature of the workforce practically inhibits professionals working together even if short term resolutions were possible. This feature fits more closely with models of education that espouse informal and experiential learning through the workplace and in relation to IPE signifies interprofessional practice rather than IPE. Researchers need to determine diverse *models of practice development* within care provision that give greater insight into what determines collaborative work.

There is some evidence to suggest that client care in the UK has developed in at least two apparently divergent ways (Land et al 1996). The first is a technical model, which emphasises the development of specific skills in the role of health

and social care professionals, termed a *model of scope of professional practice.* This approach to practice development is frequently ad hoc and reactionary to the immediate needs of service provision. An opposing model is described as a *model of scope of care*, which determines expanded practice through a holistic care model. The latter approach shows a more proactive way of planning and developing role functions.

The culture of the organisation is a major influence on practice development (Mhaolrúnaigh 1997; Laurenson 1995). If such is the case, one could assume that if a 'learning culture' is promoted the possibilities of influencing teamwork and outcomes of care are greater. Take for example, if purchasers and providers of health care were to impose a statement of intent into strategic planning that emphasised and valued the organisation as a *learning organisation*, steps could be made to proactively plan interprofessional/multiagency practice development. The model of such practice development would need to implicitly focus on *scope of care* where all players have important role functions within an interprofessional/multiagency range of practice. Education, thus learning, should act as the bond between individuals and groups in practice development and ultimately the delivery of care packages to clients. Continuous assessment, implementation and evaluation of the processes and outcomes of such developments would be essential. Collaboration between teachers is essential for multiprofessional/multiagency education.

The purpose of interprofessional education differs from multiprofessional education. Lawson (1999) proposed that the problem is not simply building bridges but restructuring through a common vision of a supportive community.

The role of teachers is pivotal to this type of education. Universities must provide leadership and a social responsibility (Lawson 1999).

As non-professionals can be equal partners in IPE, this in itself assumes another educational model, the *community learning model,* with a new language developed from amalgamation and transformation of languages of the participating parties. In the context of IPE, community learning has to constitute group learning through interaction and dialogue and address reacculturation (Bruffee 1993) of professions.

If the outcomes of interprofessional education include developing a workforce that can and will work in tandem and in harmony, all learning cannot be within the classroom environment alone. Workplace learning has to play an equal part in the development. The development of teachers has to address how they can best approach collaborative teaching and learn how to accommodate group learning (Dechant et al 1993; Gilbert et al 2000) and a new way of thinking.

The conceptual framework proposed by this investigation uses the theories of collaborative education and community learning and expands this thinking to combine learning within an organisational culture that promotes learning as the core value (Cope 1998; Senge 1990). In so doing, the thesis draws on the nonfoundational curriculum as proposed by Bruffee (1993). He proposed that learning is inherently an interdependent sociolinguistic process, and that collaborative learning assumes that knowledge is a consensus reached among members of a community.

Bruffee's (1993) collaborative learning combines interdependences and the authority of knowledge. Cope's (1998) framework deals with the integration of learning through the organisation to lead the organisation in the learning processes, while Senge's (1990) view of personal mastery and lifelong learning could help to sustain the organisation as a creative as opposed to reactive organisation with commitment to the welfare of all. Collaborative learning incorporates learning a *new language* through viewing the world from other professional viewpoints. The learners enter into *translation communities* (Bruffee 1993) and new learning begins. Senge (1990) states that learning a new language means learning how to converse with one another in the new language. Learning teams learn how to learn together. They develop a deep trust and a rich understanding of the uniqueness of individual views. In the presence of genuinely shared vision, defensive routines become unlocked and are used for shared understanding and collective learning (Senge 1990).

It is possible to develop and implement any one or all of the models discussed but not before the following conditions are embraced:

a) Teachers are aware of the purpose, processes and potential outcomes from both strategic and operational positions
b) Teachers are prepared for the role
c) Collaboration and experience are valued

The conclusion drawn from the investigation is that the efforts made by teachers to fulfil their role are underestimated. There is a need for clear guidelines on what

is considered IPE and what and how educational establishments can achieve best models of practice if an impact on practice is a prerequisite. Tuohy (1999) viewed the content of teacher development as requiring attention to three needs in particular. Initially, the teacher is concerned about extrapersonal issues for quality in teaching. Teachers in IPE certainly aired this view to reflect the technical aspects of their role through tangible examples of content and teaching strategies. Secondly, the teacher is concerned with relationship characteristics, namely interpersonal development. Teachers in IPE considered the interpersonal attributes of the facilitator as an essential constituent of the learning milieu. Finally, intrapersonal development according to Tuohy (1999) reflects the teacher's sense of personal mission within the organisation and the support mechanisms for meaningful career development. Intrapersonal growth ultimately affects the quality of interaction and the whole approach to strategic planning in the organisation. Teachers in IPE were disillusioned rather than contented with organisational schemes for implementing IPE.

7.3.1 Implications for IPE Policy

The call for a seamless service demands mutual trust, understanding and role identify. As the government's intentions are to broaden the horizon for IPE, it is imperative that organisations value *learning* and encompass the idea of a learning organisation where the personal mastery of the teacher and collaboration between teachers are dominant. If institutions are to foster competencies for interprofessional and intersectoral collaboration, recognition and reward must be given for creativity and commitment in education (Engel 2000). *Interprofessional*

education in any setting is unlikely to prosper if it is done on the cheap (Knapp and Associates 1998 p110).

Some of most difficult aspects for teachers in IPE were managing the education and balancing the vested interests of university colleagues and professional bodies' requirements for the courses. Even so there were those who felt that this concept has lots of potential. If organisations are to become learning organisations, learning disabilities must be recognised and dealt with. These disabilities can be summed up as *teams full of people who are incredibly proficient at keeping themselves from learning* (Senge 1990 p25).

Cope's (1998) *Integrated Learning Model* can facilitate organisations towards learning. This model aims to bridge two schools of thought, namely organisational learning and knowledge management. The ten-component model creates a framework to help organisations understand the processes of learning, sharing and use of knowledge within the organisation. There are two dimensions to this model. Firstly, there are four core principles, which are outlined in Figure 7.1.

Figure: 7.1 Integrated Learning Model

1. Individual:	*Intellectual capital*
2. Interactive:	*Nature of connectivity between people*
3. Infrastructure	*Transportation of knowledge through the organisation*
4. Intent	*Strategy*

Secondly, each core principle has supporting components. The components supporting the *individual* principle relate to learning as a subjective activity whereby the individual is valued and is motivated through self and organisational recognition of strengths. The individual has technical know-how, but it is also about their *interaction* and synthesis through sharing. Building a knowledge *infrastructure* for knowledge to transcend levels in an organisation requires consideration of the foundations of the knowledge structure that underpins the transfer and the diffusion processes knowledge goes through when socialised across the organisation (Cope 1998). For *intent* the underpinning components signify how a learning strategy reflects organisational learning.

The integrated learning model considers three key components of interaction to counteract blocks in knowledge transition. These are the shadow organisation or two tribes theory, relationships must be seen as a living force capable of self organising, and ideas and knowledge must be socialised effectively. Before embarking on this innovation, people involved should be encouraged to go through *a process of mapping the terrain* so that the political climate is overt (Cope 1998 p128). Professionals themselves mostly do mapping, as *they know best* (Lawson 1999). However, the results of this study show how the hidden political agenda and *tribal agenda* of different professions resulted in poor organisation and planning of IPE. The hidden and shadow features, as Cope describes them, effect knowledge transference, knowledge creation and diffusion. The teachers should be afforded the *two tribes*, to express the organisational agenda. Secondly, the educational establishments relied more on a mechanistic model where people defined their role objectives and place in the hierarchical

tree. Cope (1998) suggests that the nature of self-organising organisations place emphasis on interconnections and how the flow of information is used to achieve the objectives. Conflict between these two systems must be resolved through open dialogue before positive interaction can occur.

For IPE socialisation is a major issue requiring attention. The following quote from Cope reflects many of the organisational problems confronting teachers in IPE:

> *Developing a shared sense of purpose can aid the socialisation process but only if the alignment is truthful. Simply telling people that they have a common goal can actually result in the transfer of knowledge being corrupted or attenuated* (Cope 1998 p174)

The principles underlying this model seem apt for IPE. If applied to IPE this model would offer stakeholders in service and education, opportunity to invest in the individual's technical knowledge as a key to maintaining a competitive market. The professional and non-professional *intellectual capital* or property is the single greatest component of IPE. Collectively professional and non-professional interaction affects the process of knowledge creation and diffusion.

This means that learning groups or sets must be exposed to a climate of interaction both in the classroom and in practice environments. IPE is not multiprofessional education where the needs of all professionals are addressed. It is a new phenomenon with *new learning* where individuals change their thinking from an individualistic separatist paradigm to one of holism and collectivism. Thus, education cannot be fragmented and must be integrated to create interdependent and co-operative learning. Higher education establishments are

challenged to become community universities, something most espouse theoretically only. Interprofessional education if confined to the classroom and elitism will do little to achieve the original purpose.

If the goal of IPE is to foster integration of knowledge across disciplines, it requires a shift from the traditional paradigm of education in HE to a new paradigm of interdepartmental collaboration and a collaborative curriculum (Knapp & Associates 1998). The collaboration challenges facing universities include designing curriculum, developing team teaching and resourcing of IPE. These concerns were borne out in the experiences of one university in the USA where the planning of the innovation proved overwhelming (Knapp et al 1999). The cost implications in resourcing team teaching were heavy and sufficient time for collaboration in designing the curriculum was overlooked.

Using learning as a core value involves a change in teaching culture but also total change in the ethos of the faculty, which means dealing with *learning disabilities* within the organisation (Senge 1990). There is a need for an action-based framework for policy implementation depicting an open-ended approach to interaction and help for organisations to understand how they learn. Organisations should not just opt for a strategic template (Cope 1998).

If learning is the core value, it may lead to an organisation that is creative rather than reactive and an organisation with absolute commitment to the welfare of its people. As health care organisations are intrinsically for the benefit of the public, the culture should correspondingly be advantageous to the workforce for the development of personal mastery and quality practice. The significance of

expansion or extension of role functions could change, as could reactionary educational support to proactive educational initiatives that could only heighten competence and confidence of practitioners with their own developmental needs. These changes of course require not only commitment from strategic and operational management, but also undoubtedly, the resource implications have to be identified and overcome, with acceptance of the accompanying long term benefits.

7.1.2 Implications for Teaching and Learning

Knowing how to collaborate and to teach about collaboration is one thing but one cannot assume that collaboration happens surreptitiously. Efforts have to be made to create it and facilitate the process. Some programmes in the USA have used co-facilitators from community and faculty to enable this to happen (Knapp & Associates 1998).

In the UK, the role of the teacher has rarely been considered and the additional tasks placed on teachers to plan and implement IPE have largely been overlooked. Teachers express a need for role preparation and this preparation can only be through a collaborative venture where teachers themselves undergo the processes of sharing and developing *new learning*.

Bruffee's (1993) description of collaborative learning seems appropriate for developments in IPE. The beliefs underpinning this model have huge significance in interactive learning between professions who have their own invested interests and contested territory (Hugman 1995). The idea of professions re-examining their own background experiences and re-evaluating their position in their own

profession along with the transition to learning anew seems appropriate for diluting of unattractive boundaries. Socialisation within the organisation has to reflect different levels of participation such as individual, team, group and organisation (Tuohy 1999).

The demand for a changed pedagogy, where the teacher has to promote an interdisciplinary approach to teaching and peer relationships demands *a radical shift in thinking, and demands skills of cooperative teamwork, in planning and delivery* (Tuohy 1999 p49). Although Tuohy referred to primary and post-primary schools, the same principle applies to IPE. In its essence, IPE has the complexity of a new way of thinking and a new language for teachers.

The need for *commitment* from management to developing personal and professional mastery is of equal and even greater importance, because as Senge (1990 p142) established, the people who share a high level of personal mastery share several basis characteristics such as:

- A special sense of purpose behind their visions and goals
- See current 'reality' as an ally not an enemy
- Learn to perceive and work with forces of change rather than resist them
- Are deeply inquisitive
- Connected to others and life itself yet sacrifice none of their uniqueness
- Feel part of a larger creative process
- Can influence but cannot unilaterally control
- Live in a continual learning mode

Professional development combined with personal development has long been integral to good mentoring (for example, Levinson et al. 1978; Kram 1985;

Mhaolrúnaigh 1995). Recognition of the value of mentoring and supervision in personal and professional development within an organisation can develop a learning culture and practice, within professions, and across professions, through interprofessional interaction. Such informal and formal experiential approaches to learning can be supported by reflection in and on practice using the many frameworks we have exposure to, for example, the work of Schön (1987), Boud, Keogh & Walker (1985) and Boyd & Fales (1983).

Joyce et al's (1997) paradigm for models of teaching and learning lies in the notion that:

> *All students will change as their repertoire of learning strategies increases. As they become a more powerful learning community, they will be able to accomplish more and more types of learning more effectively. In a very real sense, increasing aptitude to learn is the fundamental purpose of models of teaching* (Joyce et al 1997 p34).

Based on this theory students require exposure to different models. This idea is substantiated in teaching health and social care students as the nature of subject matter within and across curricula varies at different stages and at different academic levels. For example, students can potentially gain exposure to all four families very early on in their education in learning psychological, biological, physiological, and social sciences within a holistic model of learning.

For IPE there is a need to move from models that depict curriculum only and teaching strategies where interaction and discourse are central. Barr et al (1999) proposes that *action learning* is a possible route towards IPE effecting client care if work-based trainers or change agents are given sufficient authority to function

in their role. Senge (1990) warns against the separation of learning from experience:

> *The core learning dilemma that confronts organisations: we learn best from experience but we never directly experience the consequences of many of our most important decisions* (Senge 1990 p23).

For teachers not to experience learning from IPE itself can perpetuate the actual phenomenon that they are trying to rectify for others.

7.1.3. Implications for Professions

> *Both professional and interprofessional education training programmes should contribute to the development of a new cadre of professionals armed with knowledge and skills, as well as a desire to incorporate the wishes of clients into their individual and collective professional practices* (McCroskey 1998 p9).

Two models the *building bridges mode,* and the *restructuring model* have been discussed. The former model reflects multiprofessional education where the current thinking leans towards competency-based approaches. However, one of the major issues for professions is the argument of IPE creating a new generalist profession. Contrary to this there are critics who favour many professions sharing specialist knowledge with each other, but equally recognising and safeguarding the intellectual property of professions.

The answer lies in the type of education required. Multiprofessional education recognises common knowledge but presently differentiates between the professions own contribution. If the ideology of IPE is to create collaboration and integration of all interested parties the current methods of teaching and learning are not achieving the stated purposes. Models of education must be structured to

accommodate the needs of the wider community. In support of this movement, higher education establishments must practice as learning organisations where personal and collective mastery are of equal significance.

In addition, communication is a key component that needs to have firm foundations and be integrated through the learning community. It cannot be taken for granted (McCroskey 1998). The different use and interpretation of language is highlighted by McCroskey, where the use of the same word *assessment* in different contexts was viewed entirely differently by social workers, nurses, doctors, teachers and psychologists.

Ultimately, teachers are the ambassadors of change and development of their role must be a priority. In conclusion:

> *Adding new courses and seminars will be less effective than reorienting existing curricula to broader themes of collaboration. If interprofessional education is merely an additive, it reproduces the same syndromes that fragment the services system, as we add new programmes on top of old ones, instead of rationalising the system. Interprofessional education must be infused throughout the curriculum, instead of becoming a new, marginal discipline with its own restrictive boundaries and, eventually, professional barriers. This infused learning can and should build on the best of our disciplinary traditions* (McCroskey 1998 p19).

This supports the notion that completely new interventions are relatively rare, according to Rossi & Freeman (1993) what exists is usually some modification of existing programmes or practices.

7.1.4 Methodological Implications

The illuminative approach adopted for this study has been a useful method to provide an overview of IPE from the views of the teachers. The study has

importance in adding the teachers' perceptions to the literature on IPE. The thesis was developed from multiple methods of investigation supported by the development of a purposeful database for analysis of qualitative findings. This approach had several advantages in focusing this study on many broad issues surrounding the concept of shared learning. There were some limitations in research design and execution of the study. Each stage of the study was directed by and linked to the previous stage with the intention to provide an overview. This method within the time span restricted any in-depth analysis of the processes that occur in shared learning as outlined by the respondents. It is acknowledged that the results can only provide a picture from the perceptions of the respondents. The number of respondents cannot account for all possible initiatives and models of IPE that may be in operation elsewhere. However, despite these limitations this evaluation has provided a framework and tools for further inquiry.

The evolution of research into IPE has reached a stage where discussion has begun to focus on the 'best' methodological approaches to address the phenomena (Barr et al 1999) This focus is not exceptional to IPE but intrinsic to researching any innovation. The argument forwarded by Barr et al (1999) favours systematic reviews of published research as valuable provided rigorous appraisal of the process and results is undertaken. There is a need for caution with the feasibility of systematic reviews when there is insufficient evidence to specify selection criteria, or, to identify and compare pertinent studies without bias. In agreement with the latter, the semantic debate is an example of consistent discussion, yet, evidence to suggest common ground in terminology is still

lacking. Tope (1999) recommends that the criteria for *interprofessional education* should be made explicit. Furthermore, there is a continuing need to evaluate the processes as they occur through action research, and rigorous research of interactive models of learning. This may determine the impact of IPE on the next generation of health and social care professionals in their learning.

7.4 Conclusion

This study investigated the views of teachers of health and social care professions in relation to their role in IPE. The data gave a picture of the characteristics of IPE, the attributes of the facilitator, teaching and learning strategies, and the implications for higher education.

Placing professionals together does not guarantee learning among or between people and may reinforce the barriers that exist (Clark 1993). This supports the argument that only programmes that include interactive learning should be properly termed IPE (Shaw 1994b). Moreover, group learning must be utilised.

The management of health and social care in the United Kingdom is undergoing constant review. This has had implications for education and training of all health and social care professions. The consequences for the preparation of teachers can be seen in the fundamental changes in the development and provision of programmes of education at all academic levels. The preparation of teachers as facilitators in IPE is essential. Preparation for IPE should infiltrate the management level to include collaborative leadership and promote collaboration among diverse groups (Knapp & Associates 1998). Community and university relationships can be fragile and require nurturing over time. It is unlikely that

these relationships will last long term or become permanent. It is important therefore to plan in practical time spans where all parties can benefit.

Jones (1986) drew the conclusion that:

> *In the absence of measures such as these we suspect that interdisciplinary learning will remain as it is now lauded by committees, practised by a few, ignored by the majority* (Jones 1986 p16)

Unfortunately, this view could equally relate to IPE, especially in the development of teachers to implement programmes. More importantly, progress will be made if time is devoted to finding out what conditions have to be met for professional and teacher education, for education to become a reality instead of a name or a slogan (Dewey 1963).

Way Forward

Higher education establishments need to invest time and commitment to IPE and develop new programmes that are purpose built to achieve the desired outcomes. These programmes must clarify the theoretical foundations guiding the objectives and be evaluated accordingly. Preparation of teachers for their role is paramount if IPE is necessary. This can be achieved by exposure to processes of dialogue between professionals, development of skills in discourse analysis, and conflict resolution. Teachers cannot be expected to remain updated, and research into their own specialist subject along with facilitating a new way of learning without recognition. Teaching and learning must maintain its stance alongside research in higher education.

References

Aldag, R J & Stearns T M (1988) Issues in research methodology *Journal of Management* 14 (2) 253 - 277.

Andrewes, C Hind, M Galvin, K. Jackson, D & Platt-Mellor S (1997) *An exploration of interprofessional working and learning in the operating department* Bournmouth University Institute of Community Studies

Areskog, N H (1995a) Multiprofessional education at the undergraduate level In: Soothill, K., Mackay, L., & Webb, C. (eds.) *Interprofessional Relations in Health Care.* London Edward Arnold. p125-139

Areskog, N H (1995b) The Linkôping case: a transition from traditional to innovative medical school *Medical Teacher* 17, 376

Audit Commission (1992) *Community care: managing the cascade of change* London HMSO

Aylett, R & Gregory K (1996) (eds.) *Evaluating teacher quality in higher education* London Falmer Press

Barr, H (1992) A double message. Editorial. *Journal of Interprofessional Care* 6(3) 205-206

Barr, H (1994a) NVQ and their implications for interprofessional collaboration In: Leathard, A. (ed.) *Going interprofessional: working together for health and welfare* London Routledge p90-108

Barr, H (1994b) *Perspectives on shared learning.* London CAIPE

Barr, H (1996) Ends and means in interprofessional education: towards a typology *Education for Health* 9 (3) 341-352

Barr, H (1998) Cochrane review of outcomes from interprofessional education *Education for Health* 11 (3) 402-408

Barr, H (2000) Working together to learn together: learning together to work together *Journal of Interprofessional Care* 14 (2) 177-179

Barr, H Hammick M, Koppel I, & Reeves S (1999) Evaluation interprofessional education: two systematic reviews for health and social care *British Educational Research Journal* 25(4) 533-544

Barr, H & Shaw I (1995) *Shared learning: selected examples from the literature* London CAIPE

Barr, H & Waterton S (1996) *Interprofessional education in health and social care in the United Kingdom; Report of a CAIPE Survey* London CAIPE

Beck, C T (1994) Reliability and validity issues in phenomenological research *Western Journal of Nursing Research* 16 (3) 254-267

Benner, P (1984) *From novice to expert: excellence and power in clinical nursing practice* California Addison-Wesley

Biggs, S (1997) Interprofessional collaboration: problems and prospects In: Ovretveit J. Mathias P. & Thompson T. (eds.) *Interprofessional working for health and social care* Houndsmills. Macmillan Press p186-201

Blake, R.R Mouton J S (1970) The fifth achievement *Journal of Applied Behavioural Science* 6 413-426

Boaden, N (1997) *Primary care: making connections* Buckingham Open University Press

Bope, E T & Jost, T S (1994) Interprofessional collaboration factors that affect form, function, and structure In: Castro & Julia (eds.). *Interprofessional care and collaborative practice* Commission on Interprofessional Education and Practice C.A Brooks/Cole Chapter 6.

Boyd, E.M & Fales AW (1983) Reflective learning: key to learning from experience *Journal of Humanistic Psychology* 23(2) 99-117

Boud, D & Feletti G (eds.) (1991) *The Challenge of problem based learning* London Kogan Page

Boud, D & Griffin V (Eds) (1987) *Appreciating adults learning*: from the learners' perspective London Kogan Page

Boud, D Keogh, R & Walker D (1985) *Reflection; turning experience into learning* London Kogan Page.

Brown, R (1988) *Group processes* Oxford Blackwell

Bruffee, K A (1993) *Collaborative learning* The Johns Hopkins Baltimore University Press

Bryman, A & Burgess R G (1994) (eds.) *Analyzing qualitative data* London Routledge

Buttigieg, M A (1990) *Teacher education project* Executive Summary London ENB

Casey, B (1997) *Academic staff in higher education: their experiences and expectations Report 3* The National Committee & Inquiry into Higher Education. *(The Dearing Report)* NCIHE HMSO

Cassiani, S B H Zanetti, M L & Pela N T.R (1992) The telephone survey: a methodological strategy for obtaining information. *Journal of Advanced Nursing 17* 576-581

Casto, M (1994) Inter-professional work in the USA education and practice In: Leathard, A. (ed.) *Going interprofessional: working together for health and welfare* London Routledge p188-205

Casto, M & Juliá M C (eds.) (1994) *Interprofessional care and collaborative practice:* Commission on Interprofessional Education and Practice C.A Brooks/Cole

Centre for the Advancement of Interprofessional Education (1995*) Annual Report October 1994 to September 1995* London CAIPE

Centre for the Advancement of Interprofessional Education (1997) *Interprofessional education: a definition* London CAIPE

Centre for the Advancement of Interprofessional Education (1999) *Promotional literature* London CAIPE

Chang, E & Simpson D (1997) The Circle of learning: individual and group processes *Educational Policy Analysis Archives* (5) February 25 1-20

Clark, P G (1993) A Typology of interdisciplinary education in gerontology & geriatrics: Are we really doing what we say we are? *Journal of Interprofessional Care* 7(3) 217-227

Cohen, E G (1994) *Designing groupwork* 2nd Edition New York Teachers College Press

Cohen, L & Manion, L (1994) *Research methods in education* 4th. Edition London Routledge

Colebatch, H .K (1998) *Policy* Buckingham Open University Press

Cope, M (1998) *Leading the organisation to learn.* London Financial Times Pitman Publishing

Council on Social Work Education (1998) *A working paper on interprofessional education principles* London CSWE. http://www.cswe.org/caseyworking.htm

Creswell, J W (1994) *Research design: qualitative and quantitative approaches* Thousand Oaks California Sage

Current Index to Journals in Education (1995) *Thesaurus additions and changes* Vol 27 (3) p325

Dechant, K, Marsick, V J & Kasl E (1993) Towards a model of team learning *Studies in Continuing Education* 15 (1) 1-13

Denzin, N K (1970) *Sociological methods: a sourcebook* London Butterworths

Department of Education and Science & Employment Department (1991) *Education and training for the 21st. century* Cmnd. 1536 London HMSO.

Department of Health (1989a) *Working for patients: White Paper on the NHS* (Cmnd.555) London HMSO

Department of Health (1989b) *Caring for people: community care in the next decade and beyond* (Cmnd. 849) London HMSO

Department of Health (1990) *National Health Service and Community Care Act* London HMSO

Department of Health (1991) *Purchase of service: practice guidance* London HMSO

Department of Health (1993) *Targeting practice: the contribution of nurses, midwives and health visitors* London DOH

Department of Health (1994a) *Nursing, midwifery and health visiting education: a statement of strategic intent* Lancashire DOH

Department of Health (1994b) Circular HSG958 LAC 95 (5)

Department of Health (1995a) *Patient's Charter* London HMSO

Department of Health (1995b*) Health Authorities Act* London HMSO

Department of Health (1998a) *Modernising health & social services*: National Priorities Guidance HSC (98) 159: LAC(98022)

Department of Health (1998b) *Information for health* London NHSE

Department of Health (1998c) *A First class service quality in the NHS* London NHSE

Department of Health (1998d) *Working together: securing a quality workforce for the NHS (The New NHS)* London NHSE

Department of Health (1998e) White Paper modernising social services London DOH

Department of Health & Social Security (1983) *NHS management inquiry* The Griffiths Report London DHSS

Department of Health Social Services Inspectorate (1991*) Training for community care; a joint approach* London HMSO

De Ville, O (1986) *Review of vocational qualifications in England and Wales* London HMSO

Dewey, (1963) *Experience and education* London Collier-Macmillan Ltd.

Dickens, S (1990) Forward In: Spurgeon P. (ed.) *The Changing face of the NHS in the 1990's* Harlow Longman

Dobson, F (1998a) *NHS Still the envy of the world* London DOH

Dobson, F (1998b) Joint guidance for the NHS and social services for the first time ever London DoH

Dunkin, M J & Biddle, B J (1974) *The study of teaching* USA Holt Rinehart & Winston

Dunlop, A Hassall, T & Challis M (1999) Professional competence development: the internal audit experience In: *Developing the capable practitioner* O'Reilly D Cunningham L & Lester S (eds.) London Kogan Page Chapter 13

Dunning, M Abi-Aad, G Gilbert, D Gillam S, Livett H (1998) *Turning evidence into everyday practice* London Kings Fund

Engel, C (1994) A functional anatomy of teamwork In: *Going interprofessional* Leathard, A. (ed.) London Routledge. P64-74

Engel, C (2000) Health professions education for adapting to change and for participating in managing change *Education for Health* 13(1) 37-43

England, D A (ed.) (1986) *Collaboration in nursing* Maryland Aspen

English National Board for Nursing, Midwifery and Health Visiting (1995a) *The Board's response to nursing midwifery and health visiting education: a statement of intent.* London ENB

English National Board (1995b) *An evaluation of shared learning in educational programmes of preparation for nurse, midwife and health visitor teachers* Research Highlights: London ENB

English National Board (1993) *Obtaining a Board funded teacher preparation place* Circular ERR/LB/22 February.

English National Board for Nursing, Midwifery and Health Visiting (1989) *Preparation for teachers* Circular 1989/63/MAT

English National Board for Nursing, Midwifery and Health Visiting (1990) *Regulations and guidelines for the approval of institutions and courses.* London ENB

English National Board for Nursing, Midwifery and Health Visiting (1999) *Standards for approval of higher education institutions and programmes* ENB London

English National Board for Nursing, Midwifery and Health Visiting & Central Council for the Education and Training of Social Workers (1992) *A Joint strategy for shared learning* London ENB/CCETSW

English National Board for Nursing, Midwifery and Health Visiting & Central Council for the Education and Training of Social Workers (1995) *Shared learning A good practice guide* London ENB &CCETSW

Field, P A and Morse, J M (1985) *Nursing research: the application of qualitative approaches.* Rockville, Maryland Aspen

Freeman, D (1991) To make the tacit explicit: Teacher education, emerging discourse, and conceptions of teaching *Teaching and Teacher Education* 7(5/6) 439-454

General Nursing Council for England and Wales & Central Council for Education and Training of Social Workers (1982) *Co-operation in training Part 1 – qualifying training.* London GNC/CCETSW

General Nursing Council for England and Wales & Central Council for Education and Training of Social Workers (1983) *Co-operation in Training Part 2* – In-Service Training. London GNC/CCETSW

Gilbert, J et al (2000) Preparing students for interprofessional teamwork in health care *Journal of Interprofessional Care* 14 (3) 223-235

Gill, J & Ling J (1995) Interprofessional Shared Learning: A curriculum for collaboration In: *Interprofessional relations in health care* Soothill et al, (eds.) London Edward Arnold. 172-193

Greene, R J Cavell, G F & Jackson S.H D (1996) Interprofessional clinical education of medical and pharmacy students *Medical Education* 30(20 129-133

Guba, E G & Lincon Y S (1989) *Fourth generation evaluation* Newbury Park, CA Sage

Hamilton, D et al (1977) *Beyond the numbers game* Houndsmills Basingstoke Macmillan

Hancock, M Villeneau, L & Hill R (1997) *Together we stand- effective partnerships* London The Sainsbury Centre for Mental Health

Harbinson, S (1994) *Shared learning in the post-qualifying framework: some lessons for Consortia* London CCETSW

Harden, R M (1998) Multiprofessional education: Part 1-effective mulitprofessionals education: a three dimensional perspective *Medical Teacher* 20(5) 402-408

Hash, V Donlea, J. & Walljasper D (1985) The telephone survey: a procedure for assessing the educational needs of nurse *Nursing Research* 34 126-127

Hevey, D. (1992) The potential of national vocational qualifications to make multidisciplinary training a reality. *Journal of Interprofessional Care* 6(4) 215-222

Hopkins, D (1989) *Evaluation for schools.* Miton Keynes Open University Press.

Horder, J (1992a) A National survey that needs to be repeated. *Journal of Interprofessional Care* 6(1) 65-71

Horder, J (1992b) Conference reports *Journal of Interprofessional Care* 6(1) 73-75

Horder, J (1993) Conference Report; Present and Furure Issues in Interprofessional Education *Journal of Interprofessional Care* 7(1) 71

Hough, L & Goad S (1991) Learning collaboration in a laboratory setting *Nursing Connections* 4 (2) 17-23

House, E. R (1978) Assumption underlying evaluation models. *Educational Researcher* 7, 4-12

Howkins, E. & Allison A (1997) Shared Learning for primary health care teams: a success story. *Nurse Education Today* 17 (3) 225-231

Hugman, R (1991) *Power in caring professions* Houndmills, Basingstoke Macmillan

Hugman, R (1995) Contested territory and community services: interprofessional boundaries in health and Social care In: Soothill, K., Mackay, L., & Webb, C. (eds.) *Interprofessional Relations in Health Care.* London Edward Arnold.

Hutt, A (1986) What exactly is the team 'approach'? *Midwife, Health Visitor and Community Nurse* 22(10) 340-350

Institute for Teaching and Learning (1999) *Learning and teaching in higher education* http//www.ilt.ac.uk/about/default.htm

Jarvis, P (1983) *Professional Education* Beckenham Croom Helm

Johnson, D W Johnson, R T & Smith K A (1991) *Cooperative learning: increasing college faculty instructional productivity* ASHE ERIC Education Reports No. 4 Washington The George Washington University.

Jones, R V H (1986) *Working together-learning together* Occasional Paper 33 London The Royal College of Practitioners

Jones, I (1992) *The teaching implications of using shared learning amongst health professionals.* Paper presented at the Nurse Education Tomorrow Conference University of Durham

Joyce, B & Weil M (1996) *Models of teaching 5^{t} Edition* Boston Allyn & Bacon

Joyce, B Calhoun, E. & Hopkins D (1997) *Models of learning –tools for teaching* Buckingham Open Uuniversity Press

Juliá, M.C & Thompson A. (1994a) Group processes and interprofessional teamwork In: Casto M & Juliá M C (eds.) *Interprofessional care and collaborative practice*: Commission on Interprofessional Education and Practice C.A Brooks/Cole Chapter 4

Juliá, M C & Thompson A. (1994b) *Essential elements of interprofessional teamwork: task and maintenance functions* In: Casto M & Juliá M C (eds.) *Interprofessional Care and Collaborative Practice*: Commission on Interprofessional Education and Practice C.A Brooks/Cole Chapter 5

Kolb D A (1976) *Learning style inventory: technical manual* Boston McBer

Knapp, M S and Associates (1998) *Paths to partnership: university and community as learners in interprofessional education* Maryland Rowman & Littlefield

Knapp M. et al (1999) The design of an interprofessional, community-responsive curriculum *Teacher Education Quarterly* 26 (4) 31-34

Kram, K E (1985) *Mentoring at work: developmental relationships in organisational life* Glemview; Illinois. Scott Foresman.

Kuhn, T.S (1970) *The structure of the scientific revolution* Chicago, Chicago University Press

Kimchi, J, Polivka, B & Stevenson J S (1991) Triangulation; operational definitions *Nursing Research* 40(6) 364-366

Laurenson, S (1995) *Health service developments and the scope of professional nursing practice: A survey of developing clinical roles within NHS Trusts in Scotland* Edinbourgh National Nursing, Midwifery and Health Visiting Advisory Committee

Land, L Mhaolrúnaigh, S Castledine G (1996) Extent and effectiveness of the scope of practice *Nursing Times* 92 (35) 32-35

Larson, M S (1977) *The rise of professionalism: a sociological analysis* Berkeley University of California Press

Lawson, H A. (1999) Two frameworks for analysing relationships among school communities, teacher education, and interprofessional education and training programmes *Teacher Education Quarterly* 26 (4) 9-30

Leathard, A (ed.) (1994) *Going interprofessional* London Routledge.

Leathard, A (1992) Interprofessional developments in South Bank Polytechnic *Journal of Interprofessional Care* 6(1) 17-23

Lee, D B & Williams P T (1994) Prospective management and longitudinal care: In: Casto M & Juliá M C (eds.) *Interprofessional Care and Collaborative*

Practice Commission on Interprofessional Education and Practice C.A Brooks/Cole

Leininger, M (1971) This I believe...about interdisciplinary health education for the future *Nursing Outlook* 19 (12) 787-791

Levinson, D J et al (1978) *Seasons of a man's life* New York Alfred A Knopf Inc.

Lewin, K (1948) *Selected papers on group dynamics* In: Bruffee K A (1993) *Collaborative Learning* Baltimore The John Hopkins University Press

Loxley, (1997) *Collaboration in health and welfare; working with a difference* London Jessica Kingsley

Luker K, Carlisle, C & Kirk S (1995) *The evolving role of the nurse teacher in the light of educational reform* London ENB

McGaghie, W C (1978) *Competency based curriculum development in medical education* WHO Geneva

Mathias, P & Thompson T (1992) 'Interprofessional training-learning disability as a case study'. *Journal of Interprofessional Care* 6(3) 231-241.

McCroskey, J & Einbinder S D (eds.) (1998) *Universities and communities: remaking professional and interprofessional education for the next century* Westport Praeger

McCroskey, J (1998) Remaking professional and interprofessional education In; McCroskey J. & Einbinder S D (eds.) Universities and Communities: *Remaking Professional and Interprofessional Education for the Next Century* Westport Praeger

Mhaolrúnaigh, S (1995) A review of mentoring relationships in nurse education *Annals of Community-Oriented Education* 8, 235-246

Mhaolrúnaigh, S (1997) *Academic Levels in Nurse Education* An Bord Altranais Conference Killiney Dublin

Mhaolrúnaigh, S Clifford, C & Hicks C (1995) *An Evaluation of shared learning in educational programmes of preparation for nurse, midwife and health visitor teachers* London ENB

Miles, M B & Huberman, A M (1994) *Qualitative data analysis* London Sage

Miller, C Ross, N. Freeman M (1999) *Shared learning and clinical teamwork: new directions in education for multiprofessional practice* London ENB

Milio, N (1979) Health professions education and the nature of modern health problems...basis for a multidisciplinary core *Health Values* 3(3) 152-160
Mortimore, P (2000) Does educational research matter? *British Educational Research Journal* 26(1) 5-24

Mostert, M P (1998) *Interprofessional collaboration in schools* Boston Allyn and Bacon

Munn, P & Morrison A (1984) *Approaches to collaboration in Scottish Secondary Schools in multipdisciplinary courses 14-16* Department of Education University of Sterling

Munro, B H & Page E B (1993) *Statistical methods for health care research* 2nd Edition Philadelphia Lippincott

NHS Executive (1995) *Building on the benefits of occupational standards* EL(95) 84 London DoH

NHSE (1996) *A community health care checklist* London DOH

NHS Executive (1997a) Circular EL 97 30

NHS Executive (1997b) *The new modern dependable* Cm3807 London

NHS Executive (1998a) *Health Minister welcomes two national training organisations* Press Release: 98/254 London DoH

Olsen, J (1992) *Understanding teaching* Milton Keynes OU Press

Oppenheim, A N (1992) *Questionnaire design, interviewing and attitude measurement* London Pinter

Owen, J W (1998) *Interprofessional education and the impact of the new White and Green Papers: a health perspective* London CAIPE

Owens, P Carrier, J & Horder J (eds.) (1995) *Interprofessional issues in community and primary Care* Houndsmills Basingstoke Macmillan

Øvretveit, J Mathias, P & Thompson T (eds.) (1997) *Interprofessional working for health and social care* Basingstoke Macmillan Press

Dunning, M (1998) *Promoting action on clinical effectiveness: from project to mainstream* PACE London King's Fund

Parlett, M & Dearden G (eds.) (1977) *Introduction to illuminative evaluation: studies in higher education* California, Pacific Soundings Press

Parlett, M & Hamilton D (1972) *Evaluation as Illumination: a new approach to the study of innovatory programmes.* Occasional Paper 9 Centre for Research in the Educational Sciences University of Edinburgh

Parsell, G & Bligh J (1998) Educational principles underpinning successful shared learning *Medical Teacher* 20 (6) 522-529

Parsell, G. Spalding, R & Bligh J (1998) shared goals, shared learning: evaluation of a multiprofessional course for undergraduate students *Medical Education* 32 304-311

Patton, M Q (1990) *Qualitative evaluation and research methods* 2nd. Edition London Sage

Patton, M Q (1997) *Utilization-focused evaluation: the new century text* 3rd. Edition Thousand Oaks California Sage

Pearson, P & Spencer J (eds.) (1997) *Promoting teamwork in primary care: a research –based approach* London Arnold

Pietroni, P C (1992) Towards reflective practice - the language of health and social care *Journal of Interprofessional Care* 6(1) 7-16

Pritchard, P & Pritchard J (1994) *Teamwork for primary and shared care: a practical workbook.* Second Edition. Oxford. Oxford Medical Publications.

Rake, M O & Mathewman J (1997) *Barriers to multiprofessional learning* Paper presented at the Association of medical education in Europe Vienna Kent Institute of Health Science University of Kent

Redfern, S (1998) Evaluation: drawing comparisons or achieving consensus? *NT Research* 3(6) 464-475

Richardson, A T (1986) *Nursing interfacing with other members of the team* In: England D A. (ed.) Collaboration in Nursing Maryland Aspen Publications

Richie, J. & Spencer L (1994) Qualitative data analysis for applied policy research In: Bryman A & Burgess R.G. (eds.) *Analyzing Qualitative Data* London Routledge p173-194

Robinson, J. & Leamon J (1999) *A documentary analysis of nursing degree curricula* London ENB

Royal College of Nursing (1997) After Dearing: the implications for health care education *The Newsletter of the RCN Education Forums* Winter London RCN

Royal Commission (1979) *Royal Commission on the NHS* Department of Health & Social Security London HMSO

Rossi, P H & Freeman H E (1993) *Evaluation a systematic approach* 5th Edition Newbury Sage

Runciman, P (1989) Health assessment of the elderly at home: the case for shared learning. *Journal of Advanced Nursing* 14(2) 111-119

Russell, K & Hymans D (1999) Interprofessional education for undergraduate students *Public Health Nursing* 16 (4) 254-262

Schön, D A (1983) *The Reflective practitioner: how practitioners think in action* New York Basic Books

Schön, D A (1987) *Educating the reflective practitioner: towards a new design for teaching and learning in the professions.* San Francisco, Jossey - Bass

Secretary of State for Health (1992) *Health of the Nation: A strategy for health for England* Cm 1986 London HMSO

Senge, P M (1990) *The Fifth discipline: the art & practice of the learning organisaiton* London Random House

Shakespeare, H Tucker, W & Northover J (1989) *Report of a national survey on interprofessional education in primary health care* London CAIPE

Shaw, I (1993) The politics of interprofessional training - lessons from learning disability *Journal of Interprofessional Care* 7(3) 255-262

Shaw, I (1994a) Locally based shared learning London CAIPE

Shaw, I (1994b) *Evaluating interprofessional training* Aldershot Avebury

Stanford, R. & Yelloly (1994) *Shared learning in child protection: a report of the ENB/CCETSW Training and Evaluation Initiative to Develop A Model of Shared Learning within Child Protection Courses* London ENB

Storrie, J (1992) Mastering interprofessionalism: an enquiry into the development of masters programmes with an interprofessional focus. *Journal of Interprofessional Care* 6(3) 253-259

Strunin, L et al (1998) Report of the conference 'CME-Making Sure it Works' Royal College of Obstetricians and Gynaecologists *Medical Education* 32(5) 559-562

Tait, I (1992) A Shared record for primary care *Journal of Interprofessional Care* 6(2) 149-153

Tannen, D (1992) You just don't understand: women and men in conversation London Virago Press.

Taylor, S Rizvi, F Lingard, B & Henry M (1997) *Educational policy and the politics of change* London Routledge

The National Committee & Inquiry into Higher Education (1997) *Higher education in the learning society.* Report of the National Committee (The Dearing Report) NCIHE HMSO

Thompson, D (1990) Developing managers in the 1990s In: Spurgeon P (ed.) *The changing face of the National Health Service in the 1990s* Harrow Longman

Thompson, N (2000) *Theory and practice in Human Services* Buckingham Open University Press

Thurgood, G (1992a) Let's work together, let's learn together *Journal of Advances in Health and Nursing Care.* 1 (4) 51-77

Thurgood, G (1992b) Let's work together, let's learn together *Journal of Advances in Health and Nursing Care.* 1(5) 13-40

Tope, R (1994) *Integrated inter-disciplinary learning between health and social care professionals: a feasibility study* PhD Thesis University of Wales.

Tope, R (1998) *The impact of interprofessional education in the South West Region: a critical analysis: the literature review* London Department of Health

Tope, R (1999) *The impact of interprofessional education in the South West Region*: a critical analysis: an abridged report London NHS Executive

Tuohy, D (1999) *The inner world of teaching* London Falmer Press

Turner, B S (1992) *Regulating bodies: essays in medical sociology* London Routledge

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) *A new preparation for practice project 2000* London UKCC

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1988) *Criteria and associated guidelines for recording of qualifications* Circular PS&D (88)03

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *Registrar's Letter* 28/1992 (UKCC)

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Fitness for practice* The UKCC Commission for Nursing and Midwifery Education Report London UKCC

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2000) *Standards for the preparation of teachers of nursing, midwifery and health visiting* London UKCC

Vanclay, L (1996) *Sustaining collaboration between general practitioners and social workers* London CAIPE

Vanclay, L (1997) Team-working in primary care *Journal of the Royal Society of Medicine* 90 (5) 268-270

Wahlström, O Sandén, I & Hammar M (1997) Multiprofessional education in the medical curriculum *Medical Education* 31(6) 425-429

Wall, J.M (1994) *Mentoring relationships in initial nurse education* MA Thesis Warwick University

Watts, M (1988) *Shared learning* London Scutari Press

Webb, D (1992) Competencies, contracts and cadres: common themes in the social control of nurse and social work education. *Journal of Interprofessional Care* 6 (3) 223-230

Weinstein, J (1993) *What are the barriers to implementing successful interprofessional training programmes* South Bank University MSc Dissertation

West, M & Poulton B (1997) Primary health care teams in a league of their own In: Pearson P. & Spencer J. (eds.) *Promoting teamwork in primary health care: a research- based approach* London Arnold p12-26

West, M A & Pillinger T (1996) *Team building in primary health care: an evaluation* London Health Education Authority

West, M A. & Slater J (1996) *Teamworking in primary health care: a review of its effectiveness* London Health Education Authority

White, T (1989) *Agencies together* A Barnardos Practice Paper: Barnardos

Wilkes, M & Bligh J (1999) Evaluating educational interventions *British Medical Journal* 318 (7193) 1269-1272

World Health Organisation (1973) *Training and preparation for teachers for schools of medicine and allied health sciences* Technical Report Series No 521 Geneva WHO

World Health Organisation (1984a) *Education and training of nurse teachers and managers with special regard to primary health care* Report of a WHO Committee Technical Report Series 780 Geneva WHO

World Health Organisation (1984b) *Health for All 2000* Copenhagen WHO Regional Office

World Health Organisation (1985) *Targets for health for all: targets in support of the European regional strategy for health for all* Copenhagen WHO Regional Office

World Health Organisation (1988) *Learning together to work together for health* Report of a WHO study on Multi-professional Education of Health Personnel, Technical Report Series 769 Geneva WHO

Appendix 1.

ENB commissioned project:

An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers

SHARED LEARNING EVALUATION QUESTIONNAIRE (1)

The aim of this questionnaire is to evaluate shared learning initiatives in courses preparing Nurse, Midwife and Health Visitor Teachers in your organisation.
In this context **shared learning** is defined as -

'a planned approach within a curriculum leading to shared knowledge and experience between groups undertaking teacher preparation programmes'

Organisation No.

NB If the contact address to which this questionnaire was sent differs to your address please note address to which any future correspondence should be sent:

Address:

Telephone No.

COURSE(S) PROFILE

The purpose of this section is to develop a profile of teacher preparation courses offered by your institution and, where relevant, any shared learning that occurs. Please complete the following 2 sections as indicated

Title of Teacher Preparation Courses at this centre	Nature of course		Number of students per course **1 = approved number** **2 = actual number**									Is shared learning an option on this course ?		Approximate percentage of course time that involves shared learning (if applicable)
☐			Nurses☐		Midwives ☐		H.V.s ☐		Others (please specify)☐			YES☐	NO☐	☐
☐	Full time☐	Part time☐	1☐	2☐	1☐	2☐	1☐	2☐	1☐	2				
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q1: Does the curriculum in your organisation promote shared learning? Yes ☐ No☐

If the answer is **yes** please proceed to **Q2**.

If the answer is **no** please proceed to **Q13.**

Q2: Please rank order <u>all</u> of the following objectives of shared learning

(1 = most important, 8 = least important)

- ☐ To develop practical skills
- ☐ To prepare student teachers for future career prospects
- ☐ To increase interdisciplinary understanding and co-operation
- ☐ To break down language barriers between disciplines
- ☐ To provide effective/efficient service for consumers
- ☐ To provide theory and practice learning opportunities on an interdisciplinary basis
- ☐ To produce competent interdisciplinary teachers through systematic planning
- ☐ To make effective/efficient use of resources

Q3: Please tick one appropriate box under each of the following questions to indicate where shared learning is incorporated into the curriculum.

3.1 In the COURSE CONTENT is shared learning evident in -

Theory & practice ☐ Theory only ☐ Practice only ☐ none ☐

3.2 Are the LEARNING OUTCOMES for each of the groups participating in shared learning the - same☐ distinct ☐ not relevant ☐

3.3 Are the ASSESSMENT PROCESSES for each of the groups participating in shared learning the - same ☐ distinct ☐ not relevant ☐

3.4 Are the AWARDS/CREDITS for each of the groups participating in shared learning the - same ☐ distinct ☐ not relevant ☐

3.5 Any comment on your answers to Q3:

Q4: **Are staff prepared for their role in shared learning?** Yes □ No□
If the answer is **yes** please indicate the level of preparation
by marking the line below

Not prepared□ □ Fully prepared□

Q5: **Are students prepared for their role in shared learning?** Yes□ No□
If the answer is **yes** please indicate the level of preparation
by marking the line below:

Not prepared□ □ Fully prepared□

Q6: **Are shared learning outcomes evaluated?** Yes □ No □ Don't Know □
If **yes**, rank in order of importance the following evaluation methods
that are most salient to your organisation (1 = most important, 7 = least important)

- □ Feedback from students
- □ Feedback from course teachers/lecturers
- □ Competency-based outcomes
- □ Feedback from clients (i.e. if shared learning occurs in practice setting)
- □ Changes in course teacher's professional performance
- □ Audit reports
- □ Others (please specify) .....
  .....

Q7.1 **Please identify which professional/educational organisations collaborate in the provision of shared learning initiatives.**

- □ Service managers/representatives

☐ Higher education representatives

☐ Nursing/Midwifery professional organisations

☐ N.C.V.Q. (for NVQs in teaching and assessing)

☐ Others (please specify)

.....

Q7.2 Please indicate if collaboration includes any of the following?

	Yes	No
Conjoint development of educational policies	☐	☐
Conjoint validation of programmes	☐	☐
Recruitment of students	☐	☐
Monitoring courses	☐	☐
Assessment of students	☐	☐
Evaluation of courses	☐	☐
Preparation of staff for their role	☐	☐
Other (please expand)	☐	☐

.....

Q8: From the experience within your organisation please rank in order of importance THREE <u>beneficial outcomes</u> of shared learning.

1. .....

2. .....

3. .....

Q9: From the experience within your organsiation please rank in order of priority
the THREE <u>main problems</u> with shared learning.

1. .....

2. .....

3. .....

Q10: Please indicate on the line how course teachers perceive shared learning

Not in favour — Completely in favour

Q11: Please indicate on the line how students perceive shared learning

Not in favour — Completely in favour

Q12: Rank the following goals regarding shared learning initiatives in order of importance to your organisation (1 = most important, 7 = least important)

- ☐ Review/credit award systems
- ☐ Develop a curriculum model/framework
- ☐ Enhance teaching/learning strategies
- ☐ Develop teachers for their role
- ☐ Extend shared learning initiatives
- ☐ Promote existing shared learning initiatives
- ☐ Others (please specify)

Q13. Any additional comment on shared learning in general.

Please include factors that influence the use of shared learning and any initiatives that are unique to your organisation (if applicable).

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE.

Appendix 2.

ENB commissioned project:

An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers

SHARED LEARNING INTERVIEW SCHEDULE FOR COURSE LEADERS

The aim of this interview is to examine shared learning initiatives in courses preparing Nurse, Midwife and Health Visitor Teachers in your organisation in more detail.

Organisation No.

Interview Date:

Place:

Course Leader: **Title:**

Participants Name (if different to course leader): **Title:**

Telephone No.

COURSE LEADERS INTERVIEW SCHEDULE

In this context **shared learning** is defined as -

> **'a planned approach within a curriculum leading to shared knowledge and experience between groups undertaking teacher preparation programmes'**

Q1. HOW DO YOU DEFINE SHARED LEARNING?

Q2. DETAILS OF CONTEXT:

Location: (eg, a dept. within the University)

Course(s) Structure

Q3. CURRICULUM CONTEXT

How is shared learning promoted?

Objectives of shared learning?

Documentary evidence?

COURSE CONTENT Theory & practice ☐	Theory only ☐	Practice only ☐	
LEARNING OUTCOMES	same☐	distinct ☐	not relevant ☐
ASSESSMENT PROCESSES	same☐	distinct ☐	not relevant ☐
AWARDS/CREDITS	same☐	distinct ☐	not relevant ☐

Q4. PROVISION OF SHARED LEARNING

(a) Organisations

- Conjoint development of educational policies
- Conjoint validation of programmes
- Recruitment of students
- Monitoring courses
- Assessment of students
- Evaluation of courses

(b) Teachers

- Preparation
- Teaching Strategies
- Examples of good practice
- Specialist versus Generic Teaching Skills

(c) Groups

- Entry behaviour of Students
- Preparation
- Evaluations

Q5. OUTCOMES

Q6. FUTURE TRENDS

Are you planning any changes?

How do you foresee teacher preparation developing?

Broad scope in curriculum-empoyment prospects-HE?

Q7. ACCESS TO STUDENT GROUPS

Appendix 3.

SHARED LEARNING EVALUATION QUESTIONNAIRE (2)

FOR COMPLETION BY: NURSE, MIDWIFE AND HEALTH VISITOR TEACHERS

An Evaluation of Shared Learning in Educational Programmes of Preparation for Nurse, Midwife and Health Visitor Teachers

(An ENB commissioned project)

THE QUESTIONNAIRE IS IN TWO PARTS:

PART ONE	This section asks for information on your experiences within the context of your teacher preparation course
PART TWO	This section asks for information on your experiences within the context of your present teaching position

DEFINITION OF SHARED LEARNING

'A planned approach within a curriculum leading to shared knowledge and experience between groups undertaking teacher preparation programmes' (ENB 1990).

Code No:

Please return the completed questionnaire in the envelope provided by .....
Many thanks for your help with this project.

PART ONE:

1. **Please indicate your age**

30 or less	☐
31-35	☐
36-40	☐
41-45	☐
46-50	☐
50+	☐

2. **Please indicate your gender** ☐ male ☐ female

THE FOLLOWING QUESTIONS RELATE TO THE TEACHER PREPARATION COURSE YOU HAVE COMPLETED

3. **Please indicate below the area for which you have had teacher preparation**

Curriculum area	Please tick
Nursing	
Midwifery	
Health Visiting	
Other (s) please specify in space below	

4. **Please indicate below the type of course attended**

Type of Course	Part time	Full time	Please tick
PGCE/Cert Ed			
PGCE			
BSc (Nurse Education)			
MSc Diploma Health Professionals			
BA Nursing/Midwifery Education Studies			
Post Grad Diploma in Education			
BEd (Hons)			
Other please specify in space below			

5. **Date of commencement of your course:** _____
Date of completion: _____

6. **Please indicate with which professional group(s) you shared learning by ticking the appropriate boxes below**

	Please tick
Nurses	
Midwives	
Health Visitors	
Physiotherapists	
Social Workers	
Occupational Therapists	
Others (please specify)	

7. **Please tick one appropriate box under each of the following questions to indicate where shared learning was incorporated into the curriculum.**

7.1 In the COURSE CONTENT is shared learning evident in -
Theory & practice ☐ Theory only ☐ Practice only ☐ none ☐

7.2 Are the LEARNING OUTCOMES for each of the groups participating in shared learning the - same ☐ distinct ☐ not relevant ☐

7.3 Are the ASSESSMENT PROCESSES for each of the groups participating in shared learning the - same ☐ distinct ☐ not relevant

7.4 Are the AWARDS/CREDITS for each of the groups participating in shared learning the - same ☐ distinct ☐ not relevant ☐

7.5 **Any comment on your answers to Q7?**

8(a) **Other people have identified the following attributes to shared learning. From your experience please indicate your level of agreement with these statements where :**

SA = Strongly Agree
A = Agree
U = Uncertain
D = Disagree
SD = Strongly Disagree.

SHARED LEARNING:	SA	A	U	D	SD
Promotes mutual understanding of roles					
Disadvantages minority groups					
Promotes creative teaching					
Helps breakdown professional barriers					
Limits teaching to principles of the topic only					
Enriches the learning process					
Increases cost effectiveness					
Can provoke anxiety in students					
Enhances personal development					
Dilutes specialist subject matter					
Encourages self-appraisal					
Causes problems in planning programmes					
Promotes collaborative teaching					
Requires specific preparation for teaching					
Creates interdisciplinary rivalry					
Is a cost cutting exercise					

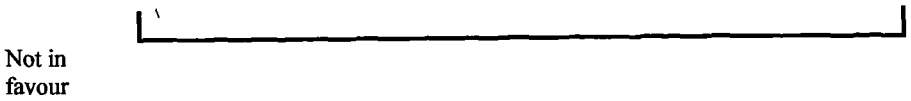
8(b). **Please state any other attributes you have personally identified that are not mentioned above**

9(a) **Please indicate on the line below your estimation of how shared learning was viewed within your teacher preparation centre**

Not in favour — Completely in favour

9(b) **Please give reason(s) for your answer**

10(a) Please *indicate on the* line how you perceive shared learning



10(b) Please give reason(s) for your answer

PART TWO:

THE FOLLOWING QUESTIONS RELATE TO YOUR EXPERIENCES IN YOUR PRESENT POSITION AS A TEACHER

11. Please complete the following questions about your orientation to your present role

Questions	Yes	No
Did you undergo an induction programme ?		
Did you observe different teaching styles?		
Did you work alongside an experienced teacher?		
Did you have a mentor?		
Did you teach in shared learning environments?		

12. Are you aware of any initiatives regarding shared learning within your college?

YES ☐ NO ☐

If **YES**, please expand

13. In your college are teachers prepared for their role in shared learning environments?

YES ☐ NO ☐

(a) If the answer is **YES** please indicate the level of preparation by marking the line below

Not prepared _____ Fully prepared

(b) Please give reason(s) for your response to 13

14. In your college are students prepared for their role in shared learning?

Yes ☐ No ☐

(a) If the answer is **YES** please indicate the level of preparation by marking the line below:

Not prepared _____ Fully prepared

(b) Please give reason(s) for your response to 14

15. In your college are shared learning outcomes evaluated?

Yes ☐ No ☐ Don't Know ☐

If **YES** please state how.

16. Please identify ANY professional/educational organisations that collaborate in the provision of shared learning initiatives.

17. We would like to know how well you believe you were prepared during your teaching course to teach students in shared learning situations

	ADEQUACY OF PREPARATION				
Statement	**Very well**	**Quite well**	**Uncertain**	**Poorly**	**Not at all**
Developing teaching strategies					
Motivating mixed groups					
Meeting needs of minority groups					
Providing relevant examples for learners					
Developing curriculum frameworks					
Other(s) please specify in space(s) below					

18. Any additional comment on shared learning in general.

Please include factors that influence the use of shared learning and any initiatives that are unique to your organisation (if applicable).

THANK YOU FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE.

Appendix 4

TELEPHONE INTERVIEW SCHEDULE .....NEW TEACHERS

Thank you for completing the questionnaire and agreeing to this follow up interview the purpose Of which is; (a) to expand on how you feel you were prepared for your role as teacher through a shared learning environment

and

(b) to gain insight into how you teach in a shared learning environment.

Q1 **How do you define shared learning?**

Prompt: - key words e.g.; unidisciplinary, interdisciplinary, multidisciplinary

Q2 **How do you define shared teaching?**

Prompt:- key words differences in- 'team teaching' and/or 'shared teaching'

Q3 **Can you give me a common example of shared learning in your present teaching practice?**

Prompt:- group composition and subject matter

Q4 **When are your students not in a shared learning context?**

Prompt: give a common example

Q5 **What consideration do you give to shared learning in your timetable planning?**

Prompt: e.g.; are students introduced to shared learning?

Referring back to your experiences on your teacher preparation course.....

Q7 **Do you use any particular approaches in your teaching within a shared learning context since course completion?**

yes	no
☐	☐

Prompt:- if yes how?

Q8 **What teaching approaches in shared learning environments were:**

(a) discussed?

(b) utilised?

(c) assessed?

Q9 **How do you motivate mixed groups?**

Q10 **(a) How do you evaluate the outcomes of these approaches?**

Prompt: What else do you do?

(b) How do the student groups evaluate these approaches?

Prompt:-of different disciplines, and/or of different areas of nursing

Q11 **How do you meet the needs of minority members or subgroups?**

Q12 **How do you provide specific examples for learners from different disciplines?**

Prompt:- give common example

Q13 **Is shared learning facilitated within an academic context only?**

yes ☐ **no** ☐

If no:
Prompt:-examples of shared learning in clinical practice own experience and/or students experience

Q14 **Is there a stage or level in nurse education where shared learning is most appropriate**

yes ☐ **no** ☐

Q15 **How do you envisage shared learning initiatives developing in nurse, midwifery, and health visiting education?**

Prompt:-pre-registration, post-registration, and teacher preparation

Appendix 5

TELEPHONE INTERVIEW SCHEDULE FOR MENTORS

- Give outline of the project and the suggested format of the interview.
- Identify the persons role in the establishment

Q1. How do you define shared learning?

Q2. Can you give me examples of shared learning in your establishment?

Q3 What are the reasons for shared learning?
Prompt: Resource driven or a strategy to enrich learning?

Q4 Do teachers need preparation to facilitate shared learning?

Q5 How do you view your role as mentor in the new teacher's development?
Prompt:- in facilitating shared learning
-how does this happen?

Q6 What teaching and learning strategies are used to facilitate shared learning?
Prompt: the processes involved in shared learning

Q7 In your experience as a mentor, what are the benefits of and barriers to shared learning ?

Q8 Did you experience shared learning in your own teacher preparation?

Q9 How do you envisage shared learning initiatives developing in nurse, midwifery and health visiting education ?

Prompt: in your establishment and nationally.

Any other comments?

TELEPHONE INTERVIEW SCHEDULE FOR MANAGERS

- Give outline of the project and the suggested format of the interview.
- Identify the persons role in the establishment

Q1. How do you define shared learning?

Q2. What are the reasons for shared learning in your establishment?

Q3. How is shared learning built into your programmes?

Q4. What are the managerial issues that need to be considered?

Q5. How do the teachers' perceive shared learning?
Prompt: and newly qualified teachers?

Q6. Do teachers need preparation to facilitate shared learning?
Prompt: reasons for your answer

Q7. Is there any specific preparation offered to the teachers in your establishment?

Q8. How do you perceive shared learning?

Q9. How do you envisage shared learning initiatives developing in nurse, midwifery and health visiting education?

Prompt: in your establishment and nationally

Any other comments?

Appendix 6

Dear Colleague,

Re: Enclosed Questionnaire

I am undertaking PhD studies on ; *Interprofessional Education for Health Professionals,* at the University of Warwick. My supervisor is Dr. Malcolm Tight in the Continuing Education Department. **For the purpose of my research, 'interprofessional education' is defined as;** any educational initiative created for health and social care professionals for the purpose of 'learning together to work together'. **'Shared learning' is therefore defined as;** a planned approach within a curriculum leading to shared knowledge and experience between groups of health and social care professionals undertaking pre and post-qualifying education.

I wish to investigate how teachers in Medicine and Professions Allied to Medicine view and experience shared learning for health and social care professionals. The enclosed questionnaire asks for information on your experiences of teaching interprofessional groups within the context of your present teaching position. I would be grateful for your assistance and if you are prepared to complete the questionnaire your anonymity will be guaranteed. If you agree to participate please return the completed questionnaire in the envelope provided by .....

In anticipation, many thanks for your help with this project.

Yours sincerely,

Siobhán Ni Mhaolrúnaigh
Senior Lecturer

Section 1

1. Please indicate your profession and the title of your Faculty

Profession	*please tick box*	*Faculty Title*
Dentistry		
Medicine: *please indicate your specialist area*		
Midwifery		
Nursing: *please indicate your specialist area*		
Occupational Therapy		
Pharmacology		
Physiotherapy		
Podiatry		
Psychiatry		
Radiography		
Sociology		
Other (s) please specify		

2. Do you find my definition of interprofessional education acceptable?

YES ☐ NO ☐ Don't Know ☐

Please indicate areas of dissagreement

3.

The purpose of this section is to develop a profile of the group(s) composition for whom you facilitate shared classroom learning
(if applicable)

Please indicate by marking a X on the grid the composition of group (s) you teach as classroom shared learning

Dentistry	Health Visiting	Nursing	Midwifery	Medicine	Occup/Therapy	Pharmacology	Physiotherapy	Podiatry	Psychiatry	Radiography	Sociology	Others (specify)

4. Are the group(s)

(a) undergraduate **Yes** ☐ **No** ☐
(b) postgraduate **Yes** ☐ **No** ☐
(c) both of the above **Yes** ☐ **No** ☐

5. What is the approximate group (s) size

	tick box
5-10	
11-20	
21-30	
31-40	
41-50	
51-60	
61-70	
71-80	
81-90	
91-100	
100+	

6. Do the students from different professions undertake shared learning in practice placements?

YES □ NO □ Don't Know □

7. Have you a teaching role for students in practice placements?

Yes □ No □

If Yes; please give a brief summary

Section 2

1 (a) Please indicate on the line how you perceive shared learning

Not in favour — Completely in favour

1(b) What reason(s) can you give for your answer to 1(a) ?

2(a) Other people have identified the following attributes to shared learning. From your experience please indicate your level of agreement with these statements where :

SA = Strongly Agree, A = Agree, U = Uncertain, D = Disagree, SD = Strongly Disagree

SHARED LEARNING:	SA	A	U	D	SD
Promotes mutual understanding of roles					
Disadvantages minority groups					
Promotes creative teaching					
Helps breakdown professional barriers					
Limits teaching to principles of the topic only					
Enriches the learning process					
Increases cost effectiveness					
Can provoke anxiety in students					
Enhances personal development					
Dilutes specialist subject matter					
Encourages self-appraisal					
Causes problems in planning programmes					
Promotes collaborative teaching					
Requires specific preparation for teaching					
Creates interdisciplinary rivalry					
Is a cost cutting exercise					

2(b). Please state any other attributes of shared learning you have personally identified and are not mentioned above

3(a) Do you think teachers require specific role preparation for shared learning environments?

YES □ NO □

3(b) Were you prepared for your role in teaching in shared learning environments?

YES □ NO □

(If you answered 'No' to 3(b) ignore the next two questions and go to 4)

3(c) If the answer is YES please indicate the level of preparation by marking the line below

Not prepared ——————————————— Fully prepared

3(d) *Did you undertake any of the following as preparation for teaching in shared learning environments?*

Preparation	**Yes**	**No**
undertook a specifically planned programme		
observed different teaching styles		
worked alongside an experienced teacher		
was allocated a mentor		
Please add other(s) if applicable		

4(a). Do you prepare students for their role in shared learning?

YES □ NO □ Don't know □

4(b) If the answer is YES please indicate the level of preparation by marking the line below:

Not prepared Fully prepared

4(c) Please give reason(s) for your response to 4 (b)

5 I would like to know how well you believe you are able to deal with the following in relation to shared learning situations

Ability to deal with situations in shared learning environments

Statement	Very well	Quite well	Uncertain	Poorly	Not at all
Developing curriculum frameworks					
Developing teaching strategies					
Motivating mixed groups					
Meeting needs of minority professional groups in the classroom					
Providing relevant examples for learners in relation to their professions					
Breaking down professional barriers					
Encouraging collaborative work					
Encouraging learners' self-appraisal					
Assessing learning through group contact					
Evaluating the effectiveness of shared learning					

6(a) Do you use any *particular* approaches in your teaching within a shared learning context?

YES ☐ NO ☐ Don't know ☐

If you said Yes to 6(a) please give examples;

7 ***Any additional comment on shared learning in general?***
Please include any factors that you feel influence the use of shared learning and any initiatives that are unique to your organisation (if applicable).

Thank you for your help in completing this questionnaire.